EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA AND LINKS TO ALCOHOL USE WITH NATIVE HAWAIIANS LIVING IN RURAL HAWAII IN THE 21ST CENTURY

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Dedication

This dissertation is dedicated to the Native Hawaiian co-researchers who so kindly agreed to participate in this exploratory study and share their stories and experiences of colonization and historical trauma. Your resilience, strength, determination and perseverance are inspirational. Thank you for contributing your stories and adding to the growing tapestry of American Indigenous people’s experiences of forced colonization. I would also like to dedicate this work to my Cherokee maternal grandfather and to my great, great grandmother Lizzie Groundhog who survived the Trail of Tears and to my ancestors who did not survive.
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Abstract

American Indigenous populations, American Indians (AIs), and Alaska Natives (ANs) have experienced historically traumatic events over the past 500 years, and Native Hawaiians (NHs) over the last 240 years from contact with Europeans, and the subsequent colonization, and appropriation of traditional homelands. Colonization resulted in massive losses of people, and culture including loss of cultural knowledge, traditions, land, and identity. The proximal issues of racism, discrimination, oppression, and marginalization have compounded the problem leaving a long legacy of unresolved historical trauma and a complex form of chronic Post-Traumatic Stress Disorder (PTSD), and unresolved grief among individuals in the tribes and groups. Indigenous scholars have posited historical trauma as a prime cause of the current social pathology among AI/AN/NH populations through the inter-generational transmission of stress leading to high rates of suicides, homicides, domestic violence, child abuse, alcohol, and substance use, and mental health disparities. AI researchers have emphasized the need to study historical trauma in relation to specific sociocultural contexts. Research exploring the impact of colonization and historical trauma has been conducted with AIs and ANs demonstrating a link between historical trauma, and increased physical and mental health disparities, alcohol, and other substance use. Little is known about the behavioral risks of substance use that may have resulted from colonization and historical trauma in NHs. There are specific cultural and historical losses which are unique to NHs who are at a higher risk for poorer mental health outcomes, and alcohol and other substance use compared to other ethnic populations in Hawaii. NHs have a history, similar to AIs/ANs, which elevates the importance of exploring their lived experience, and perceptions of colonization, historical trauma and links to alcohol use in the 21st century.
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<tbody>
<tr>
<td>ACES</td>
<td>Adverse Childhood Events Scale</td>
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<td>AHLS</td>
<td>Adolescent Historical Loss Scale of Ethnic Experiences</td>
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<tr>
<td>AI</td>
<td>American Indian</td>
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<td>AN</td>
<td>Alaska Native</td>
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<td>APA</td>
<td>American Psychological Association</td>
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<td>CES-D</td>
<td>Center for Epidemiologic Studies Depression Scale</td>
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<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
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<tr>
<td>CITI</td>
<td>Collaborative Institutional Training Institute Initiative Training</td>
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<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manuel for Mental Health Disorders</td>
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<tr>
<td>DUI</td>
<td>Driving under the Influence</td>
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<tr>
<td>FEDEX</td>
<td>Federal Express</td>
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<tr>
<td>NH</td>
<td>Native Hawaiian</td>
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<tr>
<td>HL</td>
<td>Historical Loss</td>
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<tr>
<td>HLAS</td>
<td>Historical Loss and Associated Symptoms Scale</td>
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<td>HLS</td>
<td>Historical Loss Scale</td>
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<tr>
<td>HT</td>
<td>Historical Trauma</td>
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<td>HTR</td>
<td>Historical Trauma Response</td>
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<td>HUG</td>
<td>Historical Unresolved Grief</td>
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<tr>
<td>LGEO</td>
<td>Lakota Grief Questionnaire</td>
</tr>
<tr>
<td>PRISMA</td>
<td>Preferred Reporting Items for Systematic Reviews and Meta-Analyses</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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Chapter 1: Introduction

The history of American Indigenous populations, American Indians/Alaska Natives/Native Hawaiians (AI/ANs/NHs) is reflected throughout history in their troubled relationships with the United States (U.S.) government after forced colonization (Brave Heart-Jordan, 1995; Brave Heart & DeBruyn, 1998; Brave Heart, 2003; Dickerson et al., 2018; Duran & Duran, 1995; Duran, Duran, Yellow Horse Brave Heart & Yellow Horse Davis, 1998; Pokhrel & Herzog, 2014; Wiechelt, Gryczynski, Johnson, & Caldwell, 2012). AI/ANs/NHs still deal with the destructive legacy of colonization. There are approximately 565 AI tribes, and AN groups in the U.S. that are recognized by the federal government. NHs are not federally recognized as a sovereign group and are considered Pacific Islanders. AI/ANs/NHs are the original inhabitants of the U.S. Those AI tribes and AN groups with federal recognition possess a constitutional right that allows them to be separate, and apart from the rest of the country's population. However, they and NHs remain minorities, and marginalized in their original homelands. There is little doubt that AI/ANs/NHs especially those living in impoverished urban or reservation settings continue to suffer from a startlingly high degree of psychosocial distress, physical, and mental health disparities, and alcohol, and other substance use (Wiechelt, Gryczynski, Johnson & Caldwell, 2012, Wimbish-Cirillo, 2016). AI scholars argue that the disproportionately high rates of psychological distress are the result of traumatic historical experiences due to the effects of colonization (Brave Heart-Jordan, 1995, Brave Heart & DeBruyn, 1998, Brave Heart, 2003; Duran & Duran, 1995; Duran, Duran, Yellow Horse Brave Heart & Yellow Horse Davis, 1998; Gone, 2013; Gone, 2014, Patchell, Robbins, Lowe & Hoke, 2015). Health disparities, both physical, and mental, and alcohol, and substance use in AI/AN
populations have been proposed to stem from colonization, and historical trauma experiences (Dickerson et al., 2018; Evans-Campbell, 2008; Lowe & Wimbish-Cirilo, 2016, Whitbeck, Adams, Chen & Hoyt, 2004; Whitbeck, Chen, Hoyt & Adams, 2004). AIs often cite the exemplar that historical trauma is their socio-psychological legacy as a consequence of colonization (Gone, 2014). In sum, AI/AN/NH populations whether in urban, rural, or reservation communities experience higher rates of health burdens despite the overall health, and wellness of the nation as a whole (Dickerson et al., 2018; Wiechelt et al., 2012). While research has been conducted on some AI/AN populations, the impact of colonization and historical trauma using the Historical Trauma Conceptual model (Sotero, 2006) and links to the current use of alcohol has not been explored in studies with NHs. One quantitative study conducted by Pokhrel and Herzog in 2014, used historical trauma theory to explore substance use among NH college students. The lack of research with NHs as a separate group and the lack of qualitative research with NHs daily lived experiences and perceptions of colonization and historical trauma, and links to the use of alcohol in the 21st century create an urgent need to explore the possible links between these phenomena and gaps in the current knowledge base.

Transcendental phenomenology provides a qualitative research approach, which can empower NHs to share their unique perceptions and daily experiences of these phenomena through storytelling. Not only can this qualitative approach focus on what individuals are going through daily but also, offer a means for the researcher to understand the reality of the participant’s or co-researchers’ experiences, and perceptions to gather knowledge, and contribute to the development of effective culturally sensitive, and relevant healing interventions. The context or setting will be in a rural area of Hawaii familiar to the student researcher. The exact location will not be disclosed to maintain the anonymity of the co-researchers.
In order to understand how devastating colonization and historical events affected NHs, it is essential to look at the AI historical context, and how historical trauma was conceived as a conceptual model in AIs. Additionally, for this study, the historical contexts discussed below will focus on AIs, ANs, and NHs.

**Background of the Concept of Historical Trauma in AIs**

The concept of historical trauma was first hypothesized in the 1960s. The concept was associated with the psychoanalytical case studies of the persistent trauma symptoms experienced by Jewish Holocaust survivors and their descendants after World War II (Gone, 2014; Kellermann, 2001, Brave Heart & DeBruyn, 1998). The Jewish Holocaust survivor literature provided a theoretical foundation and an applied body of knowledge for the development and expansion of the concept to include AIs. The evidence of an AI/AN/NH holocaust is abundant, and replete in the literature (Brave Heart & DeBruyn, 1998; Stannard, 1989; 1992). Contact with European colonizers brought decimation to AI/AN/NH populations through epidemics of disease, and annihilation through the military, and colonist expansion policies that forced social changes, which contributed to the loss of traditional cultures, and identity, and led to inadequate living conditions on reservations, and marginalized areas that continues to further contribute to the disruption of Indigenous cultures and traditional ways (Brave Heart, 1995; Brave Heart, Chase, Elkins & Altschul, 2011; Brave Heart, 1998; Brave Heart & DeBruyn, 1998; Stannard, 1989; Sotero, 2006; Struthers & Lowe, 2003; Weaver & Brave Heart, 1999). Further, lands with value to the U.S. government were taken, and AI/ANs/NHs were resettled and marginalized in restricted areas elsewhere. As part of the removal process, many AI people died from disease, starvation, and fatigue. (Brave Heart, 2003; Weaver & Brave Heart, 1999; Wimbish-Cirillo, 2016).
Maria Yellow Horse-Brave Heart a Hunkpapa, Oglala, Hohwoji, Lakota, social worker first conceptualized historical trauma, and unresolved grief from reflecting on the Lakota AI population's trauma experiences at the Wounded Knee Massacre, and the forced attendance, and assimilation of Lakota children in boarding schools. Brave Heart in her early psychoanalytic training encountered historical, and intergenerational trauma, and unresolved grief with Jewish survivors of the Shoah or Holocaust. She recognized a link between the genocide of the European Jews and the massacre of unarmed Lakota by the U.S. Seventh Cavalry at Wounded Knee in 1890 and began to formulate a theory that could adequately capture the Lakota historical trauma experiences. Brave Heart recognized that she carries the ancestral legacy of trauma as a lateral descendant of Tatanka Iyotake, Sitting Bull, and as a member of Wapaha Ska Tiospaye, the White Lance extended family kinship network, all descendants of the Wounded Knee survivors. Aware of her unresolved grief, she began to incorporate the theory into clinical and community work and in training and healing workshops. Post-Traumatic Stress Disorder (PTSD), a Western mental health construct, could not fully capture the experiences of the traumatic historical experiences of the Lakota. Brave Heart along with Eduardo and Bonnie Duran, also AIs, appropriated and advanced the clinical concept of historical trauma from the earlier research on Holocaust survivors to broader applicability to AIs (Gone, 2007; 2009). The early hypotheses included the surrogate terms of historical legacy and intergenerational PTSD. In 1988, building on cultural immersion and confirmatory clinical experiences Brave Heart refined her earlier hypotheses to the theoretical, conceptual model of historical trauma, unresolved grief, and historical trauma response (HTR) (Brave Heart-Jordan, 1995, Duran & Duran, 1995, Gone, 2014). Historical trauma, unresolved grief, and HTR includes a constellation of symptoms and will be defined below in the historical trauma conceptual model created by Sotero (2006).
Additionally, alcohol use introduced by European colonizers, has been passed intergenerationally to AI/AN descendants and may have also been passed down to NH descendants. Historical trauma is gaining recognition among Indigenous scholars to be a precipitating condition that significantly influences and affects present-day physical and mental health disparities and alcohol use disorders (Brave Heart and DeBruyn, 1998; Duran & Duran, 1995; Gone, 2014; Sotero, 2006). The AI/AN and NH historical contexts and the introduction and regulation of alcohol are discussed in the following sections.

The AI/AN Historical Context

The current realities of American Indigenous populations have been shaped by historical events (Struthers & Lowe, 2003). Before European explorers arrived, there was an estimated 4.4 to 12.25 million Indigenous people living in what is now the U.S. It has been posited that by 1900, after 400 years of the destructive forces of colonization, AI/AN populations had been reduced to approximately 250,000 (Szlemko, Wood & Jumper Thurman, 2006; Thornton, 1987).

The first contact with Europeans and the subsequent colonization of what is now the U.S. started a cascade of unanticipated consequences for AIs and ANs. Nothing could have prepared the Indigenous peoples for what was to follow in the coming decades and centuries. The broken treaty promises of the U.S. government that accompanied the rapid expansion of European settlers into Indigenous lands, including the deliberate slaughter of innocent people, allowed no time for AIs to grieve or rebuild societies (Charbonneau-Dahlen, 2010).

The diseases that were introduced by European contact are evidenced by the devastating decline in Indigenous populations (Charbonneau-Dahlen, 2010; Denham, 2008; 1999; 2003; 2011; Brave Heart-Jordan, 1995; Brave Heart, 1998; Stannard, 1989; Stannard,1992; Struthers & Lowe, 2003). Epidemics of bubonic plague, smallpox, whooping cough, venereal disease, pneumonia, and mumps were introduced to AIs who had limited or no immunity. Also, the
deliberate introduction of smallpox killed whole tribes in the 16th and 17th centuries (Charbonneau-Dahlen, 2010). The deliberate introduction of smallpox is documented in correspondence from Colonel Bouquet to General Amherst, dated July 13, 1763:

P.S. I will try to inoculate the Indians by means of Blankets that may fall in their hands, taking care however not to get the disease myself. As it is] pity to oppose good men against them, I wish we could make use of the Spaniard's Method, and hunt them with english dogs, supported by Rangers, and some Light Horse, who I would think effectively extirpate or remove that Vermine (Charbonneau-Dahlen, 2010; d'Errico, 2010).

Disease epidemics were one of the primary causes of the genocidal decline in AI populations and functioned as one of the primary forces in the colonial expansion (Charbonneau-Dahlen, 2010).

Additionally, alcohol use introduced to AIs by Europeans with devastating long-term consequences was another force in colonial expansion (Brown, 2003). The policies that were established regulating alcohol contributed to the massive decline in AI populations and the loss of lands. As colonizing settlers continued to move West, and AIs were forced into areas known as Indian country prohibition policies were established that forbade the selling of alcohol to AIs. These policies were motivated by concerns of AIs being childlike and unable to control alcohol consumption. Further, AI population losses were attributed to a vulnerability to alcohol. In regions where alcohol was unknown across North America, this stereotype of AI people could be maintained, and a dual legal system could be established that regulated the use of alcohol, allowing Whites to drink while criminalizing the use of alcohol in AIs. Alcohol was another means of eradicating AIs (Szlemko et al., 2006). This is evidenced in a quote from Benjamin Franklin:

“If it be the design of Providence to extirpate these savages in order to make room for the cultivators of the earth, it seems not improbable that rum may be the appointed means. It has already annihilated all tribes who formerly inhabited the seacoast” (Franklin, n.d.).
The introduction of alcohol and countless other atrocities, together with unimaginable aggression, fueled the extermination of AIs, the ethnic cleansing of the AI people.

The consequences of the loss of AIs were the loss of leaders, cultural knowledge, traditions, land, identity, and traditional ways of subsisting. The loss of culture and dispossession has been designated a primary cause of the many social and health problems of AIs today. AI leaders view health disparities and dispossession as co-occurring and as the result of historically traumatic events. Immeasurable dispossession occurred when AIs were removed from their homelands. Genocide and cultural eradication made a lasting impact on AI well-being. Disparities in socioeconomic and health status arose from inequities in wealth and power that resulted from a loss of culture and lands. AIs were left with limited resources and poor access to quality healthcare, which has persisted for the past 500 years (Charbonneau.-Dahlen, 2010). Past U.S policies fostered socioeconomic disadvantages, including resource alienation, which contributes to inadequate housing, poor education, low income, unemployment, substance use, violence, overcrowding, poor hygiene, and reduced personal, familial, and communal well-being (Cunningham and Stanley, 2003; Durie, 2004). Also, other policies that forced assimilation, segregation, and cultural pluralism have led to oppressive dynamic disempowering communities and fostering the creation of stereotypes, which continue to reinforce racism (Gone, 2014). Ultimately, the U.S. policies that sequestered AI children from their families into boarding schools forbidding traditional practices had the explicit purpose of assimilating them into the lower socioeconomic strata of mainstream society (Charbonneau-Dahlen et al., 2016; Gone, 2013).

**NH Historical Context**

Historical events, also catastrophic, impacted and threatened NH people's well-being and existence over the last two and a half centuries. Western contact, which began with the arrival of
English Captain James Cook and his crew in 1778, began a cascade of events that resulted in the near devastation of the NH people and their culture (Daws, 1974; Hope & Hope, 2003). As with AIs and ANs, contact with European colonizers and the rapid settlement of foreigners in Hawaii after 1778 almost destroyed the NH people through catastrophic disease epidemics and the loss of culture, traditions, healing practices, lands, and identity (Daws, 1974, Stannard, 1989; 1992). The history of NHs has not been dissimilar to that of AIs and ANs to the extent that all have endured colonization and social, political, and cultural suppression in their ancestral lands (Pokhrel & Herzog, 2014). Before contact with European colonizers, NHs experienced little disease or illness and had a strong economy (McMullin, 2005; Wong & Kataoka-Yahi, 2016). As with AIs the relationships between land, life, cultural beliefs, and food continues to remain deeply entrenched within the historical struggles that NHs have over land and health (McMullin, 2005).

Beginning with the arrival of Captain Cook, foreign sailors, merchants, and settlers to Hawaii in the nineteenth and twentieth centuries led to a rapid and precipitous decline in NH population. The decline in population is similar to that of the AIs. David Stannard (1989; 1992) referred to the rapid decline in Indigenous populations as a cultural genocide or holocaust. Daws (1974) also referenced an early medical account in the post-contact era that depicted the loss of NHs as a genocide. Between 1778 to 1893, ninety to ninety-five percent of the NH population died from diseases after contact with Westerners. Stannard (1989) estimated that the NH population in 1778 was between 800,000 to 1,000,000 people, and by 1893 the population had been reduced to approximately 40,000, a reduction of 95 percent. As with AI populations, disease functioned as the primary force in colonial expansion in Hawaii, leading to catastrophic historical losses. Furthermore, this author argues that the introduction and eventual regulation of
alcohol with NHs as with AIs was another force that served to expand colonialism in Hawaii during the late 18th and 19th centuries.

The Introduction of Alcohol in Hawaii

According to historical accounts the first appearance of alcohol in Hawaii was in 1780 in the form of a crude beer made by ship's Captain Nathaniel Portlock, who was part of Captain Cook's crew. The root of the ti plant found in Hawaii was fermented and baked into the crude beer as a means of preventing scurvy among the sailors. The crude beer became known as Okolehao. Later, in the early part of the nineteenth century, William Stevenson, an escaped convict from the Botany Bay penal colony of New South Wales, Australia, taught the NHs how to distill the Okolehao into liquor. The historical accounts are that the distilled version was used by Western sailors who sought a potent liquor; however, NHs sought it as well including, King Kamehameha I, who banned the strong liquor in 1818 due to the harmful effects it had on NHs (Brown, 2003).

In 1820, the American missionaries arrived in Hawaii, one year after the death of Kamehameha I and after the abolishment of the Kapu system of traditional NH laws. King Kamehameha II had ascended to the throne and was under the tutelage of his mother, Regent Queen Kaahumanu. By 1820 the population in Hawaii consisted of multiple foreign groups with global economic interests and with a cosmology that was in direct conflict with NH cosmology. Alcohol had already become an important high stakes commodity in long-distance trade. When the missionaries arrived, they had concerns over whether the Hawaiian monarchy could manage alcohol use and public disorder, both of which could interfere with commerce and trade. It was with these concerns that the missionaries exerted their influence with the Regent Queen to transition to Christian laws based on the Ten Commandments to govern the use of alcohol. These early laws were enacted in the form of oral declarations and applied to everyone (Brown, 2003;
Merry, 2000). Later in the 19th century, a unitary system of laws with dual legal codes for the legal governance of alcohol use was eventually established, one for Whites who could continue to drink alcohol and another for NHs for whom drinking had become criminalized (Brown, 2003).

As with AIs, the critique of NHs use of alcohol was part of the broader colonial discussion suggesting that NHs were not capable of political self-governance. Drinking by NHs was considered a problem but not in the same way that drinking was a problem for White people, which is illustrated in a historical account by the prominent missionary, Hiram Bingham, who characterized NH behaviors as deviant. He considered the NHs to be exceptionally vulnerable to the effects of alcohol and characterized them as inferior as compared to Whites (Brown, 2003). NHs use of alcohol was increasingly considered a threat to social order, despite that White foreign sailors and merchants use of alcohol demonstrated unwanted behaviors and also presented temptations to the NHs. Because of these views, a unitary system of laws with dual legal codes for alcohol use was established criminalizing alcohol use in NHs but not in Whites. The situation in Hawaii contrasted with other circumstances of colonial domination in the U.S. in that the NH monarchy was influenced by the American missionaries to adopt the same prohibition policies that the U.S. government enacted to control drinking among AIs/ANs. The most salient point to take away from this is the regulation of alcohol use among NHs was also a means of establishing and maintaining political autonomy over them, which further eroded NH culture and power (Brown, 2003). So, in addition to the historical losses that were incurred secondary to European and American encroachment and disease epidemics, the introduction of alcohol played a role in the breakdown of Hawaiian culture which led to the eventual illegal overthrow of the Hawaiian monarchy and the establishment of a new American colony (Brown, 2003).
Phenomenon of Interest

NH’s lived experiences and perceptions of colonization and historical trauma related to historical events experienced by their ancestors and the relationship between these perceptions and experiences and links to alcohol use in the 21st century.

The Role and Impact of Alcohol from a Western Perspective

The role and impact of alcohol use from a Western perspective and the Westernized denotation of alcohol is a maladaptive behavior that occurs continually over one year, whereby the use of alcohol results in health impairment (American Psychiatric Association, 2014; Wimbish-Cirillo, 2016). Substance misuse defined as a destructive behavior that results from the repetitive practice and pattern of substance use (Black, Grant, & American Psychiatric Association, 2014). Additionally, the definition and clinical manifestation of substance use overlap with the definition of substance abuse, its precursor (Wimbish-Cirillo, 2016).

The Role and Impact of Alcohol from an AI/AN Perspective

The AI/AN denotation of alcohol is perceived as a detrimental way of coping that has stemmed from European colonization, historical trauma, and the assimilation of AI/AN populations (Yuan et al., 2010; Wiechelt & Okundaye, 2012). Substance use concerns among AI/AN populations are seen as family and community issues as opposed to an individual one. It is perceived as cultural conflict, and a constant, multi-generational threat to the present and future survival (Beauvais & Trimble, 1995; Brave Heart et al., 2011; Wimbish-Cirillo, 2016).

Historical Trauma Conceptual Framework

Historical trauma. Historical trauma has been defined as the cumulative, emotional, and psychological wounding that is transmitted across generations, which includes the lifespan, which stems from massive group trauma experiences (Brave Heart, 1998; 2003; Brave Heart et al., 2011). Historical trauma theory frames trauma throughout the lifespan in a collective,
historical context, which empowers survivors of both individual and community trauma by reducing the stigma and isolation. The term historical loss has been used by Whitbeck, Adams et al., (2004) and Whitbeck, Chen et al., (2004) as a measure of historical trauma.

**Historical trauma response (HTR).** The historical trauma response (HTR) has been conceptualized as a constellation of features or conditions that have been associated with a reaction of affiliated groups to massive group trauma experiences. The symptoms of HTR include depression, anxiety, self-destructive behaviors, suicidal thoughts and actions, low self-esteem, anger, and difficulty recognizing and expressing emotions. Also, the use of alcohol is considered a means of avoiding these painful feelings through self-medication (Brave Heart et al. 2011).

**Historical unresolved grief.** Historical unresolved grief is a component of HTR. This component has been defined as the profoundly unsettled bereavement that results from devastating cumulative losses. Losses have been compounded by the interruption and prohibition of traditional ceremonies and burial practices (Brave Heart et al. 2011). Whitbeck Adams et al. (2004) found that thinking about historical trauma is associated with psychological and emotional distress, especially depression and anger.
Figure 1. Conceptual Model of Historical Trauma (from Sotero, 2006).

**Historical Trauma versus PTSD**

Historical trauma is an expanded, more complex manifestation of PTSD, which affects affiliated groups of people, rather than individuals, and which is passed on to subsequent generations through intergenerational mechanisms, which remains the focus of much debate.

PTSD is a mental health disorder that is characterized by severe and long-term effects of exposure to traumatic stressors such as combat, sexual assault, child abuse, motor vehicle accidents, and natural disasters. Experiences of chronic trauma create considerable emotional scars that can affect life-long patterns of behaviors, interpersonal relationships, role performance, and the ability to develop skills (Gone, 2009; 2013; 2014). The American Psychiatric
Association (2013) officially entered PTSD as a psychiatric and mental health diagnosis into the Diagnostic and Statistical Manual of Mental Disorder (DSM) in 1980. The diagnostic criteria include the following: a) experiencing direct or indirect exposure to trauma, b) intrusive thoughts and re-experiencing the trauma, c) avoidance, d) negative mood; e) hyperarousal and reactivity; f) symptoms lasting for one month or longer in duration; g) cause significant functional impairment; and h) is not attributable to the physiological effects of a medication, substance, or another medical condition (American Psychiatric Association, 2013, pp. 271-274).

An important change was added to the DSM-5 criteria, which expanded the earlier versions of the PTSD diagnostic criteria to include indirect exposure to trauma, learning of an event that has occurred to a friend or family member, and repeated exposure to details of the events. The addition of the new criterion confirms that intergenerational trauma is a phenomenon that can be diagnosed in psychiatric and mental health settings and measured in research. Most research on psychological trauma has primarily focused on the psychological effects of individuals rather than on group trauma exposure (Sotero, 2006).

The concept of historical trauma is more complicated in antecedents, evolution, and consequences than PTSD, which has a direct cause, course, and consequences. PTSD is a disorder of individuals, whereas historical trauma is a collective disorder of affiliated groups, and, which incorporates both the social and psychological sequelae of historical oppression. Cumulative trauma is when multiple traumatic experiences are said to have an increasing impact over time, which is then passed on to subsequent generations through social and biological intergenerational mechanisms. Historical trauma theory assumes that the descendants of the individuals who have experienced historical trauma are more susceptible to pathological and psychological dysfunction as a result of the experiences their ancestors endured, independent of their own experiences. Historical trauma theory consolidates and proposes within an explanatory
model, a dichotomy or chain of causality between the colonial agents of oppression, and the oppressed Indigenous groups who experienced genocide, violent conquest, reservation confinement, religious oppression, forced assimilation, and ongoing poverty, and discrimination (Gone, 2013; 2014, Kirmayer, Gone & Moses, 2014; Hartman & Gone, 2014). Historical trauma theory provides an explanatory power that goes beyond the traditional social determinants of health for a single lifespan (Gone, 2014; Walters, Mohammed, Evans-Campbell & Beltran, 2011). Some proponents of historical trauma have proposed that parental communication is the mechanism of secondary transmission of psychological trauma (Gone, 2013; Palacios & Portillo, 2009; Walters et al., 2011). It has been posited that because historical trauma theory arose from three simultaneous publications in 1995, and parental communication has been proposed to be a method of secondary transmission of psychological trauma; historical trauma should be considered as a comprehensive, socio-psychological explanatory model based on descent group (Gone, 2013).

**The Historical Trauma Socio-Psychological Explanatory Framework**

A historical trauma socio-psychological explanatory framework highlights the potential and relevance of using a traditional approach informed by Story theory through storytelling methodology as a means of exploring the experience and perceptions of the cumulative, and intergenerational impact of historical trauma (Gone, 2013). Storytelling methodology has the potential of linking past collective experiences of others to those in present time (Brave Heart, 2003; Smith & Liehr, 2014), since it has been posited that parental communication is a mechanism of secondary transmission of psychological trauma (Gone, 2013; Palacios & Portillo, 2009). There is widespread interest in historical trauma by scholars in many disciplines. However, there are unique challenges in this area of research: (1), how to make sense of the
abundant and diverse research literature and (2) how to integrate the literature with theory to advance scientific inquiry.

**Figure 2.** Socio-Psychological Explanatory Model: The Transgenerational Transmission of Historical Trauma transmitted across generations through multi-level processes including epigenetic mechanisms of stress response: Changes to an individual's psychological well-being, self-efficacy, self-esteem, family functioning, community integrity, and cultural identity, the continuity of identity and the collective efficacy of whole groups of people (from Kirmayer & Gone, 2014).

**Story Theory**

While Brave Heart’s (2011) conceptual framework of historical trauma has provided the overarching principles guiding this research, Sotero (2006) has provided a comprehensive diagram of the conceptual framework and Kirmayer & Gone (2014) have provided a socio-psychological explanatory framework to illustrate how experiences of trauma can be transmitted across generations. Story theory will provide specific guidance for the descendants of those who experienced historically traumatic events to tell their stories (Smith & Liehr, 2014). The consistency between the transcendental phenomenological philosophical approach, the Historical
Trauma theory, the historical trauma conceptual model and diagram, the socio-psychological explanatory framework and the concept of Story theory and the NH ‘talk story,’ storytelling method will guide this study and explore the lived experiences, and perceptions of colonization and historical trauma and the current use of alcohol in NHs in the 21st century. The major components of Story theory are discussed below.

Storytelling has the potential to heal and to build theory into practice and research. The central ontology is that a story is an inner human resource for making meaning, and the epistemology is based on middle-range theory, which links research, and practice in a method of knowledge development. The theory intends to engage an individual to intentionally talk about what matters to them about a complicated health challenge (Smith & Liehr, 2014). The human story is a health story in a broad sense in that it communicates an individual's current life situation to clarify present meanings about the past with a focus on the future while in the present moment. The assumptions of Story theory are consistent with unitary, and neo-modernist perspectives, and are non-reductionistic in that people transform and transcend in a reciprocal process with their environment and are in alignment with Indigenous circularity. This fluid process is a way of creating meaning, which is critical to a unitary perspective that depicts a narrative happening in a story and throughout time. The healing power of a story can continue throughout life in this manner (Smith & Liehr, 2014).

Story theory is comprised of three interrelated concepts: a) intentional dialogue, b) connecting to self-in-relation, and c) creating ease. The assumptions are that individuals, 1) change as they interrelate with their world in a vast assortment of flowing interconnected dimensions, 2) live in an expanded present where the past and future are transformed in the present, and 3) experience meaning as the understanding of the creative progression of human potential. The first assumption grounds sensitivity in the complex nature of a stories dimension
in a manner that elucidates an individual's moving with, through and beyond their evolving story. The second assumption directs the focus to be on the storyteller's present experiences and with the listeners understanding that their unique perspective includes both the present, past, future. The third assumption supports the human propensity to create meaning through awareness of thoughts, feelings of bodily experience, and behavior and other human expressions all in the progression of the unfolding health story (Smith & Liehr, 2014).

Intentional dialogue is the robust engagement with another individual to summon a story about their life experiences including health challenges, grief, and act as a catalyst that can bring about the process of change. Storytelling must happen in a trusting relationship in order to discover what is happening and by paying attention to the unfolding flow of a story, and both the storyteller and researcher come to know better who they are and about each other. The process of intentional dialogue can empower the experience of being alive by revealing what matters the most to the individual telling the story. By giving full attention to the storyteller, the researcher communicates to them that they are worthy of listening to and that they have undivided attention and respect (Smith & Liehr, 2014).

There are two processes of intentional dialogue, which are true presence and querying emergence. True presence is a non-judgmental method of being able to focus, and refocus the energy on the storyteller, and being open to hearing their story. It is the process of being able to be human at the moment while at the same time giving self over to the other who is exploring the meaning of the situation (Liehr, 1989). To attend to an unfolding story is the assumption that true presence seeks to clarify the patterns that connect the beginning, middle, and end of a story. Querying the emergence of a story is the clarification of aspects of a story that remain unclear; nothing can be assumed about a story; the storyteller is the only one who knows the details.
Further, there is always more to a story, it is never finished, and aspects may remain that the storyteller does not want to share (Smith & Liehr, 2014).

**Connecting with Self-in-Relation.** The active process of recognizing self in relation to others in a story is the process of connecting with self-in-relation. Hall and Allan (1994) identified self-in-relation as a central concept in their model, which focused on the meaning of the concept for nurse-client interactions, noting that “self is created in relation to others (p.112). Story theory is the process of connecting with self-in-relation and of the reflective awareness of personal history that evolves into a story and follows the life path as the storyteller recollects it. The researcher encourages the reckoning with personal history by starting with the past to arrive at the story beginning, middle, and the future to find the unique meanings that lie hidden in the ambiguities.

Reflective awareness is the opposite of taking life for granted and the individual’s ability to be in touch with their perceptions of the world, and their place in it, and more concretely at the moment. This process allows the storyteller to be able to become aware that experiences, thoughts, and feelings are separate, and distinct from themselves as opposed to being personal defining qualities which allows an individual to be mindful at the moment, and has the potential to shift their relationship with thoughts, and emotions to a greater clarity (Smith & Liehr, 2014).

**Creating Ease.** The release of energy as the story emerges is the process of creating ease. The two aspects of creating ease are being able to remember fragmented story moments and flow in the midst of anchoring, which connects the events in time through the process of realization, acceptance, and understanding as the health story fragments sort, and converge as a meaningful whole. Patterns begin to surface as the storyteller elucidates the meaning of important experiences. As the patterns become evident, anchoring and flowing happen simultaneously, and meanings surface, allowing clarity (Smith & Liehr, 2014).
**Relationships among the concepts: The model.** The current model depicting Story theory demonstrates how the flow of energy between the storyteller and listener develops as the story unfolds. In the shared flow of energy, all of the concepts of Story theory merge, which includes all of the story processes. A story is a narrative that happens as self-in-relation, which connects to an internal dialogue to create a sense of ease, and ease emerges as the storyteller accepts the story. Notably, these concepts are in a dynamic flowing inter-relationship in keeping with Indigenous circularity (Smith & Liehr, 2014). 'Talk story,' is a powerful NH tradition of storytelling and sharing formation with cooperation and empathy as with other traditional Indigenous storytelling methods. Traditional storytelling methods can initiate a noncompetitive dialogue that is focused on creating balance, harmony, and healing in group experiences (Daley et al. 2006).

![Theoretical Model of Story Theory](image)

Figure 3: Theoretical Model of Story Theory. (from Smith and Liehr, 2014).

**Problem Statement**

Current studies have illuminated that AI/AN/NH populations experience a disproportionately higher rate of mental health issues. Additionally, among AI/AN/NH there is a high prevalence of alcohol and other substance use. AI/AN/NH also have shorter life expectancies than other Americans. Finally, these groups experience significantly higher
rates of cigarette smoking, alcohol, suicide rates, and traumatic exposure (Beals et al., 2013; Dickerson et al. 2018). All these health disparities have been postulated to stem from colonization and historical trauma exposure. These public health issues create an urgent need to reduce the gap in AI/AN/HI adverse health indices. Colonization, historical trauma, and alcohol use have been studied in some AI and AN populations. As with those AI and AN groups who have not yet been studied in context, qualitative studies are also needed to explore NHs lived experience and perceptions of colonization, historical trauma and the use of alcohol in order to be able to help contribute to the development of culturally congruent interventions for health promotion and to decolonize health care and support American Indigenous liberation by resisting Western medical Interventions where they are not wanted.

**Purpose of the study**

The purpose of this study is to explore the lived experiences and perceptions of colonization and historical trauma and links to alcohol use in the 21st century that may be related to traumatic events experienced by their ancestors among NHs living in a rural area of Hawaii.

**Research Question**

What is the lived experience and perceptions of colonization and historical trauma and links to the use of alcohol in NHs living in a rural area of Hawaii in the 21st century?

**Significance**

The findings of this research will contribute to the growing knowledge base of culturally appropriate research methods for populations who have been impacted by colonization and historical trauma. By using a storytelling telling approach to explore the lived experience and perceptions of colonization, historical trauma, and links to the use of alcohol will help to provide inroads into understanding the impact of these phenomena on NH mental health disparities and current use of alcohol.
Definitions of Terms

1. American Indian: An individual, a descendant of the original Indigenous peoples in the U.S. before colonization who has been determined to be a member of one of the 565 Federally recognized AI tribes in the U.S. as determined by the policies of their tribe.

2. Alaska Native: An individual, a descendant of the original Indigenous peoples in the U.S. before colonization who is a member of a Federally recognized Alaska Native group in the U.S. as determined by the group’s policies.

3. Native Hawaiian- A self-identified individual who is a descendant of the indigenous people living in Hawaii before Western contact in 1778.

4. American Indigenous populations- American Indians (AIs), Alaska Natives (ANs), and Native Hawaiians (NHs) who are either members of one of the Federally recognized tribes or groups or NHs who self-identify as the descendants of the people living in Hawaii before Western contact in 1778.

Assumptions

1. Because of experiences of colonization and historical trauma experienced by the NHs, it is important to gather stories using an appropriate, culturally sensitive means of exploring their lived experiences and perceptions of colonization, historical trauma and links to alcohol use in order to be able to contribute to the development of effective culturally sensitive interventions to reduce mental health disparities and alcohol use.

2. The NH 'talk story,' methodology can provide a traditional NH culturally sensitive way of gathering stories that are in keeping with the circular cosmology of American Indigenous populations and Story theory.
3. ‘Talk story,’ will help facilitate storytelling for NH co-researchers to describe their lived experience and perceptions of colonization and historical trauma and the links to the use of alcohol in the 21st century.

Limitations

1. The sample for the study will be drawn from NHs in a specific context, living in a specific rural area of Hawaii, known to the student researcher, to the exclusion of other contexts in Hawaii.

2. The co-researchers’ agreement to participate in the study will not ensure their participation, which may result in a decrease in the sample size.

3. The purposive sampling method may create selection bias.

Summary of Chapter 1

The effects of colonization have resulted in conditions that affect the psychological, social, economic, political, intellectual, physical, and spiritual realms of AIs/ANs/NHs. A link has been established between colonization and historical trauma, loss, and states of disharmony and imbalance in AIs who experience considerably higher rates of mental health disparities, and alcohol and other substance use than other populations. Additionally, they live shorter and more challenging lives due to much higher rates of exposure to traumatic events (Armenta, Whitbeck & Habecker, 2016; Balsam, Huang Fieland, Simoni, & Walters, 2004; Beals et al., 2013; Dickerson et al., 2018; Ehlers Gizer, Gilder & Yehuda, 2012; Herne et al., 2014; Kaholokula et al., 2006; Manson et al., 2005; Martell et al. 2016; Myhra, 2011; Myhra & Wieling, 2014; Pokhrel & Herzog’s, 2014; Substance Abuse and Mental Health Services Administration (SAMHSA), 2015; Tucker, Wingate, & O'Keefe, 2016; Walls & Whitbeck, 2012; Weaver & Brave Heart, 1999, Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004).
History provides a narrative within which current social issues can be interpreted. By integrating a rich understanding of NH history into social science research on health, we can improve the cultural relevance of research findings and enhance interventions. NH history includes colonization, trauma, and the introduction of alcohol. The questions becomes in what ways historical trauma may or may not be present or impactful and how we as people respond to history in order to help promote resilience. A narrative on historical trauma can offer a framework for analyzing how colonization and historical trauma and links to the use of alcohol have been transmitted and connected to the present-day context.
Chapter 2 Literature Review

Purpose of the Review

The purpose of this literature review on colonization and historical trauma in Indigenous American populations is to examine, analyze, synthesize and appraise the current knowledge and research with AIs, ANs, and NHs and links the use of alcohol. This review of the literature is guided by several questions. What is the current knowledge on this topic, what areas of research are absent and what can be added to the current knowledge base through future research endeavors?

Background

In 1995, the concept of historical trauma and other related concepts emerged in three concurrent mental health publications explicitly related to AI and AN concerns regarding ongoing health disparities (Brave Heart-Jordan & DeBruyn, 1995; Duran & Duran, 1995; Gone, 2014; Terry, 1995). First, Maria Brave Heart conceptualized historical trauma as it pertained to the Lakota AI population's trauma experiences (Brave Heart-Jordan & DeBruyn, 1995). Second, psychologists Eduardo (Tewa Apache) and Bonnie (Opelousas/Coushatta) Duran promoted soul wound, a similar concept, which was already an integral part of Indigenous knowledge associated with colonial oppression (Duran, 2006; Duran & Duran, 1995; Duran et al., 1998; Gone, 2013; 2014). Finally, Michael Terry (1995) an adult nurse practitioner practicing in community health settings in Alaska while working with ANs also referenced the concept of historical trauma concerning ongoing Native health disparities.

Significance

A review of the literature on American Indigenous historical trauma produced many articles on theory development, position papers, data and statistics from professional, state and national organizations but a limited amount of quantitative and qualitative studies. Most of the
studies on historical trauma were focused on AI and AN populations and one quantitative study that specifically focused on measuring historical trauma and substance use in NHs. The lack of studies that specifically address colonization and historical trauma in NHs and links to the use of alcohol is a gap in the American Indigenous historical trauma literature.

Methodology

A literature search was conducted for this systematic literature review using the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed Medline, Web of Science, Psychological Information Database (PsychINFO), Abstracts in Anthropology, Sociological Abstracts and GOOGLE Scholar from 1995 through 2018. Studies from 1995 to 2018 were screened and reviewed from peer-reviewed nursing, psychology, sociology, anthropology, medical and scientific and core journals. The Preferred Reporting Item for Systematic Reviews and Meta-Analyses (PRISMA) established an organized guideline to complete a systematic literature review (Moher, Liberati, Tetzlaff & Altman, 2009). The initial search heading included HT, HTR, unresolved grief, and intergenerational transmission. These terms were combined with key terms NHs, Hawaiians, Pacific Islanders, Indigenous, AIs, Native Americans, and ANs. Combinations of these search terms were used to make sure that any relevant articles would not be missed since there is a paucity of literature on the topic of colonization and historical trauma, NHs and links to alcohol use. Additionally, MeSH terms were used with related words and titles to broaden the search. The titles and abstracts were scanned to determine relevance using the inclusion criteria and articles were selected that directly pertained to the research question. Only quantitative and qualitative articles relating to colonization and historical trauma and NH, AI and AN populations in the U.S. were included. The combined search produced (324) articles.

Inclusion/Exclusion Criteria
The inclusion criteria from the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed Medline, Web of Science, Psychological Information Database (PsychINFO), Abstracts in Anthropology, Sociological Abstracts, Academic Search Premier and Google Scholar were as follows: (a) published date from January 1995 to October 2018, (b) English language, (c) peer-reviewed, and (d) age group: all ages. Additionally, there were research studies on physical health disparities and the epigenetic transmission of HT sequelae that were omitted. Any studies that did not include HT, alcohol use, misuse or abuse were omitted from the review. Also, studies published before 1995 were excluded.

Data Abstraction

The initial numbers of records identified from the eight databases based on the inclusion criteria. The studies were divided into categories, historic/historical trauma and AI, Native American, AN, NH, Hawaiian and alcohol use/abuse within all categories. Abstracts of 324 articles were selected and reviewed by the author. After removing (19) duplicate articles, 305 articles were remaining. Two hundred and seventy-three (273) articles were excluded based on both title, and abstract reviews including position papers, data and statistics from professional, state and national organizations. Thirty-two articles were included for a full review. Twelve (12) were rejected because they were not empirical articles. Finally, a total of 20 articles were chosen and used in the literature review. There were 11 quantitative studies and 9 qualitative studies.

Salient Findings on Historical Trauma

Brave Heart seminal studies. The return of the Sacred Path was a quantitative study conducted by Brave Heart in 1992 and published as her dissertation in 1995. This study was the preliminary step in the formulation of historical trauma theory concerning the Lakota AIs. The assertion was that the Lakota suffer from impaired grief as a consequence of considerable and cumulative trauma throughout history. The study examined the effectiveness of a culturally
congruent four-day psychoeducational intervention that was designed to begin the process of
grief resolution with a group of 45 Lakota service providers. The methodology included
assessments at three different intervals and used the Lakota Grief Experience Questionnaire
(GEQ), semantic differential, self-report evaluation, and a six-week follow-up questionnaire. The
data were analyzed using measures of central tendency, frequency, descriptive statistics, paired t-
tests as well as a t-test for independent samples. The results of the study confirmed that: a)
education about historical trauma would lead to an increased awareness of associated effects, and
b) that sharing these effects in a traditional context would provide cathartic relief. The study
participants affirmed the usefulness of historical trauma theory in facilitating a healing process
(Brave Heart, 1998; Brave Heart-Jordan, 1995). Table 1 and 2 reflect the reduction in effects
over time and significant changes in the Lakota GEQ.

Table 1. Effects Experienced Before and After the Intervention

<table>
<thead>
<tr>
<th>Affect</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>66.7%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Grief</td>
<td>54.5%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Pride</td>
<td>51.5%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Anger</td>
<td>69.7%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>45.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Shame</td>
<td>60.6%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Helplessness</td>
<td>54.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Joy</td>
<td>45.5%</td>
<td>75.8%</td>
</tr>
<tr>
<td>Guilt</td>
<td>60.6%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>
Table 2. Reduction in Grief and Trauma Components on the Lakota GEQ from T1 to T2

<table>
<thead>
<tr>
<th>Affect</th>
<th>M (T1)</th>
<th>M (T2)</th>
<th>P</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame</td>
<td>3.21</td>
<td>2.67</td>
<td>.004</td>
<td>P &lt; .01</td>
</tr>
<tr>
<td>Stigmatization</td>
<td>2.92</td>
<td>2.31</td>
<td>.001</td>
<td>P &lt; .01</td>
</tr>
<tr>
<td>Anger at U. S.</td>
<td>3.15</td>
<td>2.87</td>
<td>.012</td>
<td>P &lt; .05</td>
</tr>
<tr>
<td>Obsessive Thoughts</td>
<td>3.38</td>
<td>2.79</td>
<td>.007</td>
<td>P &lt; .01</td>
</tr>
<tr>
<td>Feeling blame for WK massacre</td>
<td>2.63</td>
<td>1.96</td>
<td>.023</td>
<td>P &lt; .05</td>
</tr>
<tr>
<td>Feeling responsibility for undoing the pain of Lakota people’s past.</td>
<td>3.04</td>
<td>2.46</td>
<td>.004</td>
<td>P &lt; .05</td>
</tr>
</tbody>
</table>

Brave Heart and DeBruyn (1998) in a qualitative study examined the effects of internalizing historical trauma in an exploratory study with former boarding school residents that included five Lakota tribal members, two women, and three men. Focus group methodology was employed as the participants shared their boarding school experiences. The group discussions were video and audiotaped, and field notes were taken to capture accurate data, which was coded and categorized for themes. The participants shared personal stories of abuse and neglect during the time that they were at the boarding schools. Moreover, the participants related continued feelings of anger regarding their boarding school experiences. Resilience emerged as one of the major themes among the Lakota participants concerning how the historical trauma experiences were managed (Brave Heart, 1999). Additionally, this study provided valuable insight into the use of storytelling methodology to explore the cultural narratives of Indigenous populations who have experienced historical trauma and resilience as a possible outcome.

Brave Heart (1999a) in a qualitative study examined gender roles and differences and other risk factors associated with trauma among the Lakota. An examination of traditional gender roles and adaptations engendered by traumatic Lakota history were examined within the lens of
historical trauma theory. A historical trauma intervention focusing on cumulative trauma response through brief intensive psychoeducational group experiences was delivered to 45 Lakota men and women service providers and community leaders. The goals of the intervention were to impart a sense of mastery and control over their circumstances despite experiences of oppression and cumulative historical traumatization within a safe haven, sacred Paha Sapa (Black Hills). The participants were exposed to historical trauma memories and opportunities for cognitive integration that are necessary for effective treatment. Large and small group process provided opportunities for verbalization of traumatic experiences which led to a decrease in psychosomatic symptoms, reduced psychic numbing and increased affect tolerance. Traditional Lakota culture and ceremonies were integrated throughout the intervention, which had a curative effect on PTSD symptoms. Self-report measures were taken at three intervals. At the end of the intervention, all of the participants (100%) felt the intervention was helpful in healing historical trauma and unresolved grief. Additionally, all trauma-related effects were reduced by 50 to 100%. At the second interval, women's anger decreased more than men's and all participants were less sad and felt less guilt and shame and felt more joy.

Table 3. Gender Differences in Boarding School Experiences

<table>
<thead>
<tr>
<th></th>
<th>Percent Male</th>
<th>Percent Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended boarding school</td>
<td>82.4%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Hit at boarding school</td>
<td>85.7%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Punished for speaking Indian Language</td>
<td>57.1%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Experienced racism in boarding school</td>
<td>85.7%</td>
<td>58.5%</td>
</tr>
<tr>
<td>Sexually abused at boarding school</td>
<td>28.6%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

Table 4. Gender Difference in Traditional Presentation of Self

<table>
<thead>
<tr>
<th></th>
<th>Percent Male</th>
<th>Percent Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking mostly or purely Indian</td>
<td>61.1%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Speak Indian</td>
<td>47.1%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Parents spoke Indian</td>
<td>94.1%</td>
<td>76.9%</td>
</tr>
</tbody>
</table>
Actively participate in powwows | 61.1% | 46.2%
Listen to Indian music frequently/often | 44.4% | 53.8%
Eat Indian food frequently | 16.7% | 23.1%
Wean Indian clothing/jewelry frequently | 38.9% | 32.0%
Practice Indian spirituality frequently | 27.8% | 53.8%

Table 5. Group Totals and Gender Differences for Effects Experienced Often Before and After Intervention

<table>
<thead>
<tr>
<th>Group</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>66.7%</td>
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</tr>
<tr>
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<td>54.5%</td>
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</tr>
<tr>
<td>Hopelessness</td>
<td>45.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Shame</td>
<td>60.6%</td>
<td>6.1%</td>
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<tr>
<td>Helplessness</td>
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</tr>
<tr>
<td>Joy</td>
<td>45.5%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Guilt</td>
<td>60.6%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Before</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>70.6%</td>
<td>73.3%</td>
<td>11.8%</td>
<td>26.7%</td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>70.6%</td>
<td>66.7%</td>
<td>5.9%</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td>70.6%</td>
<td>53.3%</td>
<td>0.0%</td>
<td>13.3%</td>
<td></td>
</tr>
<tr>
<td>Shame</td>
<td>64.7%</td>
<td>60.0%</td>
<td>0.0%</td>
<td>13.3%</td>
<td></td>
</tr>
<tr>
<td>Joy</td>
<td>58.8%</td>
<td>33.3%</td>
<td>70.6%</td>
<td>86.7%</td>
<td></td>
</tr>
</tbody>
</table>

Brave Heart (1999b) conducted a qualitative study the focus of which was Oyate Ptayela or the rebuilding of the Lakota Nation by addressing historical trauma. Brave Heart delivered the Wakanheja curriculum intervention to a group of ten Lakota parents and two Lakota parent facilitators on a Lakota reservation. The study presented evidence that suggested that historical trauma affected Lakota parents and children by changing parenting behaviors and placing children at risk for alcohol and other substance use. The curriculum incorporated information about historical trauma and reattachment of Lakota values with the emphasis on traditional
protective factors for alcohol and substance use prevention for Lakota children. The focuses of the curriculum were on, a) facilitating parental awareness of lifespan and collective trauma across generations, and b) reattachment to Lakota values.

Table 6. Major Emergent Themes

| “Impact of historical trauma upon parenting.” | • Parents more aware of how historical trauma from boarding schools’ experiences affected their parenting skills.  
| | • Recognition that they lack parenting skills.  
| | • Many parents are drinking and using drugs and neglecting their children.  
| | • Gain increased awareness and better able to communicate about boarding school experiences.  
| | • Became aware of shame and disgrace related to boarding school experiences.  
| | • Recognition that the community should help them work through bad experiences rather than using drugs and alcohol and abusing children. |

| “Transforming in parenting.” | • The parents reported becoming more aware of their children from a traditional Lakota perspective.  
| | • Increased recognition of how sacred their children was which improved bonding.  
| | • Recognition that there was a need to focus on self-healing and recognition that they needed to get in balance to be role models. |

| “Re-cathexis to traditional Lakota values.” | • Recognized their lack of knowledge about Lakota culture.  
| | • Became awed at the beauty of the Lakota belief system.  
| | • The curriculum affected their interactions with children and made them more aware of the importance of passing on traditional culture and language. |
Weaver and Braveheart (1999), conducted a quantitative study on multicultural identification in seven northeastern Native communities. The study tested whether Native youth identified with more than one culture. Two sites, the Powhatan Renape Nation in New Jersey and the St. Regis Mohawk Nation in New York were based on reservations. A total of 103 youth between the ages of 8 and 12 years of age completed cultural identity questionnaires. The youth were asked questions to establish which cultures they identified with and the strength of the identification. They could identify with as many cultures as they felt were relevant. The scores were summed to create five cultural scales including, (1) AI, (2) White American, (3) Spanish/Mexican American, (4) African American, (5) and Asian American. The lower scores indicated alienation from a culture while higher scores indicated a connection to culture. There were not significant differences between sites on the White American scale (p = 0.083). Highly significant differences between sites demonstrated on the African American scale (p = 0.004). The results indicate that at some of the sites the youth identified with African American culture while at other sites they did not. The findings of the study indicated that the youth strongly identify with more than one culture, which supported the orthogonal model of cultural identification. The large standard deviations at some sites indicted that within-site differences exist in how strongly the youth identify with various cultures.
Table 7: Cultural Identification

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>N</th>
<th>MEAN</th>
<th>SD</th>
<th>MIN</th>
<th>MAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>103</td>
<td>9.381</td>
<td>3.526</td>
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<td>20</td>
</tr>
<tr>
<td>White American</td>
<td>103</td>
<td>5.829</td>
<td>3.978</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Spanish/Mexican American</td>
<td>103</td>
<td>2.067</td>
<td>3.249</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>African American</td>
<td>103</td>
<td>2.552</td>
<td>3.715</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Asian American</td>
<td>103</td>
<td>0.914</td>
<td>1.344</td>
<td>11</td>
<td>20</td>
</tr>
</tbody>
</table>

**Review of Historical Trauma Literature**

Twenty articles were reviewed for this literature review that met inclusion criteria. Several similar themes were identified, including historical trauma, historical loss thinking, historical consciousness, unresolved grief, historical and associated losses, transgenerational, intergenerational transmission, affective disorders and alcohol and substance misuse, discrimination and enculturation.

**Historical loss thinking.** Whitbeck, Chen et al., (2004) in a quantitative study introduced the Historical Loss questionnaire (HLS) among a group of AIs in the upper mid-west to investigate the effects of discrimination, enculturation and historical loss on meeting the diagnostic criteria for 12-month alcohol use in a sample of 452 (351 women) parents and caregivers aged 29 to 42 years of children ages 10 to 12 years. Nearly three fourths (73.5%) of the adults in the sample (81.4% men; 71.1% women) met the DSM-III-R criteria for lifetime alcohol misuse and 15.1% met the criteria of 12-month criteria for alcohol misuse. One-fifth of the participants had thoughts about the loss of lands, 36.3% had thoughts daily or several times daily about the loss of language, 33.4% had thoughts of loss of spirituality which increased to 54.8% on a weekly basis. Additionally, 33.2% thought of the loss of culture with alcoholism on their minds and only 7.5% never thought about alcohol and 45.9% thoughts of it daily or more.
Losses due to early death were on the minds daily of 33.2% and 54.5% weekly. Loss of respect by children of traditional ways was on the minds of 35.2% and weekly by more than 52.8% of adults. Sixty-five percent of elders had thoughts of loss of respect on a weekly basis. The study presented important new evidence that historical losses affect AI alcohol misuse and also, evidence for resiliency with the effects of enculturation on alcohol misuse. Historical loss mediated the effects of perceived discrimination on alcohol misuse on AI women. Perceived discrimination was positively associated with historical loss which in turn was positively associated with alcohol misuse in women.

Whitbeck, Adams et al., (2004) in a quantitative study developed a Historical Loss Associated Symptoms (HLAS) questionnaire based on confirmatory factor analysis with 143 AI adult parents of children ages 10 through 12 years who were part of a longitudinal study underway on two AI reservations in the Midwest and Canada. Both the HLS and the HLAS were found to have high internal reliability. The frequencies indicated that the current generation has more frequent thoughts regarding historical losses and that these losses are associated with negative feelings and that they may be more susceptible to historical traumas adverse psychological effects. The most frequent emotional responses to historical losses were sadness and depression (16.%), anger (38.1%), and intrusiveness of thoughts (48.7%). One-fifth (21.4%) either always or often felt uncomfortable around White people and 44% felt this way sometimes. One-third felt that policies that led to historical losses were happening again and 31% sometimes avoided places or people that reminded them of historical losses. Alcohol use was associated with historical losses. Enculturation was found to have protective effects. It was suggested that discrimination is a trigger for historical loss thoughts.

Balsam et al., (2004) in a quantitative study developed a historical trauma scale, using a modified Traumatic Events Questionnaire (Fullilove et al., 1993) composed of 14 adverse
historical experiences. The researchers specifically examined differences by sexual orientation. The researchers asked 25 lesbian, gay, bisexual and two-spirits and 154 heterosexual self-identified AIs living in the New York City area to provide yes/no answers about if they or family members within four previous generations had experienced each of the 14 adverse experiences. The findings indicated that historical trauma is significantly higher among LGBT/two-spirits as compared to heterosexual AIs. Two-spirits were significantly more likely than heterosexuals to report having experienced childhood abuse (40.0%, 20%, respectively) by a parent or adult caregiver, lifetime sexual abuse (40.0%; 20.0%, respectively), lifetime sexual assault (48.0%; 35.1%, respectively) and being physically attacked (60.0%; 48.3%, respectively). Additionally, Two-spirit participants reported significantly more experiences of historical trauma experienced by parents, grandparents, and great-grandparents than their heterosexual counterparts. The use of the historical trauma Adverse Experience Scale affirmed links between historical trauma and depression, PTSD and substance misuse.

Jervis et al. (2006) conducted a quantitative, evidence-based study exploring attitudes towards attitudes and knowledge of historical events drawn from two AI tribes. The sample was drawn from tribal rolls and included 3,084 participants, including males and females between the ages of 15 to 54 years between 1997 and 1999. Structured interviews were used to examine psychiatric diagnosis, risk, and protective factors and service use from two culturally and geographically distinct AI communities. The study measured the frequency of individual thoughts about historical loss and perceptions of community impacts of cultural losses and historical experiences. They evaluated self-reported degrees of educational levels and cultural identification and other sociodemographic variables. The findings were a significant prevalence of thoughts about adverse historical events among the 951 participants who identified personally with an ancestor (93%) who experienced the events. Additionally, links were established
between the outcomes and community location, age, educational experiences and degrees of
cultural identification. They concluded that historical consciousness, varies within and between
AI communities in ways that need to more fully explored before clear links between negative
psychological outcomes and historical trauma can be drawn. Additionally, those with a high
degree of historical consciousness considered tribal history to be important to their communities
Morgan and Freeman’s (2009) and Gone (2013; 2014) also emphasized localized differences in
cultural context to illustrate historical trauma experiences.

Cross, Day and Byers (2010) in a qualitative study interviewed 31 AI grandparents in
Michigan concerning reasons why they had taken charge of their grandchildren. In their
explanations, the participants referenced thoughts regarding boarding school experiences noting
that they wanted to protect their grandchildren from the loss, separation, and maltreatment that
they and other family and community members had experienced.

Wiechelt et al., (2012) in a quantitative study examined the relationship between
historical loss thinking and substance abuse behaviors and lower family cohesion in 120 urban
AIs. The top losses that participants thought of daily and weekly were a loss of respect by
children and grandchildren and government officials, losses from the effects of alcoholism. The
most common loss associated symptoms were sadness and depression, anger and anxiety,
avoiding places and people that were triggers and loss of sleep. Forty-one percent of the
participants reported the past 30-day use of alcohol. The study demonstrated that the participants
with the higher historical loss symptoms scores had a higher likelihood of using alcohol within
the past 30 days. Additionally, urban AIs reported higher degrees of historical trauma compared
to reservation samples in past research, lifetime use of non-marijuana drugs and lower family
cohesion. The participants reported frequent thoughts about historical losses which were
associated with family cohesion.
Ehlers et al., (2012) in a quantitative study investigated the frequency of historical loss thoughts and associated symptoms in AIs (309 men and women of equal proportions) living on reservations in eight contiguous reservations, that were influenced by contemporary events, PTSD, cultural affinity, percent of AI heritage, substance dependence, affective disorders and conduct, and antisocial personality disorders. The findings were that 94% of the participants reported having experienced traumatic events and that more women (38%) received a diagnosis of PTSD than men (29%). Multiple traumas and sexual abuse were more highly associated with PTSD. Those who experienced assaultive trauma and exhibiting PTSD symptoms were found to be moderately heritable in association with the intergenerational transmission of parental PTSD. Affective disorders such as anxiety or depression and having a substance use disorder were significantly correlated with having a diagnosis of PTSD. The study suggested that trauma is prevalent in AI communities and is also heritable and associated with diagnoses of affective disorders, PTSD and substance use. Also, that PTSD and substance use develop early in this population.

Pokhrel and Herzog’s (2014) quantitative study of 128 NH college students examined the relationships between historical trauma, perceived discrimination and substance use including alcohol, cigarette, and marijuana use. Eighteen to twenty percent of participants reported that their grandparents, great-grandparents were forced not to speak the Hawaiian language or practice traditional ways, prohibiting hunting, fishing and food gathering and being subjected to non-Natives visiting or living on Native lands. Eighty-one percent reported thinking about the loss of ancestral land, 87% reported thinking of the loss of language, and 66% thought of the loss of respect from poor treatment by government officials and between 12% and 15% reported thinking about the loss of respect of children for elders and traditional ways. The most commonly reported forms of ethnic discrimination included being treated with lack of respect,
with less courtesy and as being less intelligent. The results of the study had two pathways to substance use, an indirect pathway to higher substance use through perceived discrimination as well as a direct pathway to lower substance misuse. The conclusion was that knowledge, experience, and thoughts that are associated with historical trauma could increase substance misuse behaviors by increased perceived discrimination, however having pride in cultural heritage and identity may be protective against substance misuse.

Tucker et al., (2016) in a quantitative study investigated how aspects of ethnic minority experiences in AI and ANs influence the frequency of historical loss thinking and the symptoms of depression. The participants completed the Adolescent Historical Loss Scale of Ethnic Experiences (AHLS) and the Center for Epidemiologic Studies-Depression Scale (CES-D). The results indicated a strong ethnic identification and a desire to want to socialize predominantly with other AIs. Also, perceptions of discrimination were directly related to symptoms of depression. Approximately 25% to 30% of the participants endorsed thinking monthly or more about historical losses including the loss of people, spiritual ways, language, and the loss due to alcoholism. The most common thoughts were due to the loss of culture (34%). This provides support for Whitbeck, Adams, et al. (2004), that thoughts of historical loss are not restricted to older AIs who may have experienced trauma.

Armenta et al., (2016) evaluated the longitudinal measurement properties of the HLS to understand the consequences of historical losses, the studies of which are limited due to the lack of valid instruments. A sample of 636 Indigenous adolescents from a single cultural group were interviewed to test the theory that historical loss can be mentally distressing. The participants in face to face interviews completed the HLS measure and anxiety measures at four different points by 1 to 2-year intervals. The results were explained by a three factors including cultural losses, loss of people and cultural mistreatment. The findings were that the participants had frequent
thoughts of historical losses that were associated with anxiety. Their results indicate that historical loss can be psychologically distressing for Indigenous adolescents.

**Intergenerational trauma transmission.** Denham (2008) in a qualitative, ethnographic study of multiple generations within a single AI family, describes telling stories of traumatic events from the family's history from the 19th century to current family members. The participants did not experience psychological distress, but incorporated the events into a framework for interpreting experience and achieving specific social goals of naming children after designated ancestors and using narrative practices to teach others that the family had experienced traumatic events, but not the associated symptoms. This study is one of the most explicit responses to calls from scholars to focus on resilience that was articulated in the early 2000s.

Myhra (2011), explored in a qualitative study the intergenerational transmission of historical trauma among AI and ANs in culturally specific sobriety maintenance programs. The participants reported experiencing continuing traumatic stress from historical trauma, intrafamilial trauma, racism, poverty and poor health. Substance abuse was strongly associated with the negative impact of historical trauma and personal experiences of microaggressions and intrafamilial traumas.

Walls and Whitbeck (2012) in a quantitative study of the multigenerational effects of relocation experiences on Indigenous family groups focused on historical trauma as a contributor to AI health disparities including alcohol use, and to the benefits of treating cultural loss as a source of stress. They examined the multigenerational effects of relocation experiences on AI family groups. The participants living on Indian reservations reported higher levels of drinking problems. The grandparent generations relocation experiences were significantly associated with drinking and the drinking problems were significantly associated with other substance use
problems and depressive symptoms. A significant association found between intergenerational depressive symptoms, the effects of relocation programs, increased drinking and substance use and lower rates of supportive parenting.

Myhra and Wieling (2014) explored in a qualitative study the intergenerational effects of multiple traumas on AI’s lived experiences related to substance use. The participants reported having experienced a large number of traumatic events that were regularly related to substance use and of having experienced a large number of traumatic events that were related to the substance use of perpetrators. Many of the traumatic events described involved both parents and children and were linked to the onset of alcohol misuse. The participants reported physical abuse, sexual abuse, accidents, tragic losses of life and family violence and most of the participants experienced multiple, cumulative lifetime traumatic experiences. Thematic findings about intergenerational vulnerabilities, particularly the risk factors included compromised mental health, discrimination, and racism with subthemes of traumatic memories of boarding school and poverty.

Goodkind, Hess, Gorman, and Parker (2012) in a qualitative study examined historical trauma (as a structural frame for health inequities), and current structural stressors, building on individual and community strengths through healing and social transformation in a Navajo (Dine) community. The goal was a collaborative effort as part of a community and university to promote mental health and well-being. They conducted more than 74 interviews with 37 Dine parents, youth and grandparents about historical trauma. The youth did not believe that historically traumatic events had any negative impact on their lives; however, the elders felt that the effects of historical trauma had an impact on disease, alcoholism, substance misuse, unhappiness, violence, early death and lack of health. The older participants connected current problems with poverty and violence exposure in their community to the disruption of cultural
knowledge and practices due to intergenerational trauma. This study revealed a historical consciousness among many Dine elders but limited historical narratives among the parents and youth. These studies provide a growing body of empirical evidence that the experiences of historical trauma are prevalent and have some connection to adverse mental health outcomes in AIs.

**Synthesis of the seminal studies.** In the 1990s, Brave Heart used a series of focus groups to conduct several exploratory studies with the Lakota (Teton). Brave Heart's (1995, 1999a; 1999b) early studies focused on the AI Holocaust to explore historical trauma and continued thoughts of historical losses related to past traumatic events that were incurred at the Wounded Knee Massacre and boarding schools. Her findings were that the associations between ancestral and contemporary unresolved grief were reflected in the comments of some participants stating that they continued to feel victimized, to experience grief and remain unable to separate themselves from past traumatic events (Brave Heart, 1999b; Brave Heart and DeBruyn, 1998; Brave Heart et al., 2011; Weaver & Brave Heart, 1999). The characteristics of the Lakota historical trauma response were found to be congruent with those identified in the Jewish Holocaust Survivor Syndrome (Brave Heart & DeBruyn, 1998; Keehn, 1980; Niederland, 1988) and survivor's child complex. The Lakota historical trauma response features also included alcohol and other substance use. Brave Heart's seminal studies demonstrated that the Wounded Knee Massacre and boarding school incidents were the foundation of unresolved grief and continuing intergenerational trauma perpetuation among the Lakota people (Brave Heart et al., 2011; Brave Heart and DeBruyn, 1998; Weaver & Brave Heart, 1999).

**Historical Loss Thinking**

Eight quantitative studies presented important evidence that historical loss thinking related to past traumatic experiences of ancestors is prevalent among AIs (Balsam et al., 2004;
Cross et al., 2010; Jervis et al., 2006; Pokhrel & Herzog, 2014; Tucker et al., 2016, Wiechelt et al., 2012; Whitbeck, Adam et al., 2004; Whitbeck, Chen, et al., 2004). In one study, the current generation was found to have the most historical loss thoughts, which associated with negative feelings (Whitbeck, Adams et al., 2004). Another study demonstrated that participants had a high-level historical loss thinking regarding to the loss of family cohesion, loss of respect from children, grandchildren, government officials and losses due to alcohol use. Urban AIs reported higher degrees of historical trauma and historical loss thinking than those residing on reservations (Wiechelt et al., 2012). In the study on NHs, 87% of the participants had historical loss thoughts about loss of language, 81% about the loss of lands and 66 % of loss of respect (Pokhrel & Herzog, 2014). A study regarding AI LGBT/two-spirits found that historical trauma and historical loss thinking are significantly higher among AI LGBT/two-spirits compared to heterosexuals (Balsam et al.,2004). Another study found that AI grandparents referenced historical losses and historical loss thinking secondary to boarding school experiences and the desire to protect their grandchildren from loss, separation and maltreatment as well as the desire to protect their grandchildren from loss, separation and maltreatment (Cross et al., 2010). One study established that the most pervasive historical loss thoughts were about loss of culture (Tucker et al., 2016).

**Historical loss thinking and affective disorders.** Four quantitative studies presented evidence for historical loss thinking and the development of affective disorders (Armenta et al., 2016; Ehlers et al., 2012; Wiechelt et al., 2012; Whitbeck, Adams, et al., 2004). In one study with AIs, the most frequent psychological effects related to historical loss thinking were depression, anger, and intrusive thoughts (Whitbeck, Adams, et al., 2004). Another study demonstrated that participants with a higher level of historical loss thinking also, had symptoms of depression, anxiety, insomnia, anger, and avoidance of triggers or reminders of historical
losses (Wiechelt et al., 2012). Armenta et al., (2016) found that frequent thoughts of historical losses were associated with anxiety. Ehlers et al’s, (2012) study found that that 94% of the participants had experienced a traumatic event and that multiple traumatic events including sexual abuse were highly associated with PTSD, substance use and affective disorders which were heritable.

**Historical Loss Thinking and Discrimination**

Four quantitative and one qualitative study presented evidence that historical loss thoughts and discrimination are associated (Myra & Wieling, 2012; Pokhrel & Herzog, 2014; Tucker et al., 2016; Whitbeck, Adams, et al., 2004; Whitbeck, Chen et al., 2004). Discrimination was found to be a trigger for historical loss thinking (Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004). Pokhrel and Herzog, (2014) found that the NH participants who experienced historical loss thoughts also reported experiencing discrimination from government officials. The most common type of discrimination included lack of respect, less courtesy and being perceived as less intelligent. Discrimination was also associated with the higher use of substances. In one qualitative study, the thematic findings regarding intergenerational vulnerabilities or risk factors included discrimination, poor mental health and racism with subthemes of traumatic memories of poverty and boarding schools (Myhra & Wieling, 2014). Tucker et al., (2016) found that perceptions of discrimination were directly related to depressive symptoms.

**Historical loss thinking and substance use.** Four quantitative and two qualitative studies presented evidence that historical loss thinking is associated with substance use (Myra, 2011; Myhra & Wieling 2014; Pokhrel & Herzog, 2014; Walls & Whitbeck, 2012; Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004; Wiechelt et al., 2013;). In two quantitative studies using the HLS and the HLAS questionnaires, both with high internal reliability, established that historical loss thinking is prevalent among AIs and is associated with the use of
alcohol (Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004). Additionally, discrimination was found to be a trigger for historical loss thinking and perceived discrimination was positively associated with historical losses and historical losses were positively associated with alcohol misuse in women. In another study the participants with higher historical loss thinking had a higher likelihood of using alcohol within the past 30 days (Wiechelt et al., 2012). In a study on the perceived experiences of discrimination and historical loss thinking among NHs there was a higher use of substances among NHs (Pokhrel & Herzog, 2014). Another study established that the participants reported having experienced many traumatic events related to the use of substances and of having experienced a large number of traumatic events related to the substance use of perpetrators. Additionally, many of the traumatic events described involved both parents and children and were linked to the onset of alcohol misuse (Myhra & Wieling 2014). Another study found that drinking and other substance use was significantly associated intergenerational depression symptoms, the effects of relocation programs and lower rates of supportive parenting (Walls & Whitbeck, 2012). Myhra’s (2011) study on the intergenerational transmission of historical trauma among AIs and ANs found that the participants reported experiencing continuing traumatic stress from historical trauma, intrafamilial trauma, racism, poverty and poor health. Substance abuse was strongly associated with the negative impact of historical trauma and experiences of microaggressions and intrafamilial traumas.

**Intergenerational historical trauma transmission.** One quantitative and three qualitative studies presented evidence that historical trauma experiences can be transmitted intergenerationally through history (Goodkind et al, 2012; Myhra & Wieling, 2014; Myhra, 2011, Walls & Whitbeck, 2012). In one study on the intergenerational transmission of historical trauma among AIs and ANs, the participants reported experiencing continuing traumatic stress from historical trauma, intrafamilial trauma, poverty and discrimination (Myhra, 2011). Another
study examined the multigenerational effects of relocation experiences on AI family groups. An association was found between intergenerational depressive symptoms and the effects of relocation programs (Walls & Whitbeck, 2012). Another study explored the intergenerational effects of multiple traumas on AI’s lived experiences related to substance use. The participants reported multiple, cumulative lifetime traumatic experiences. The thematic findings about intergenerational vulnerabilities, particularly the risk factors included compromised mental health with subthemes of traumatic memories of boarding school experiences (Myhra & Wieling, 2014). Goodkind et al.’s., (2012) study examined historical trauma (as a structural frame for health inequities) and current structural stressors, building on individual and community strengths through healing and social transformation in a Navajo (Dine) community. The youth did not believe that historically traumatic events had any negative impact on their lives. The elders felt that the effects of historical trauma had an impact on disease, alcoholism, substance misuse, unhappiness, violence, early death and lack of health. The older participants connected current problems with poverty and violence exposure in their community to the disruption of cultural knowledge and practices due to intergenerational trauma. This study revealed a historical consciousness among many Dine elders but limited a historical coconsciousness among the parents and youth.

**Historical consciousness, enculturation and contexts.** Three quantitative and two qualitative studies presented evidence that experiences of historical trauma, historical loss thinking, and historical contexts varies within and between cultural groups (Denham, 2008; Goodkind et al., 2012; Jervis et al., 2006; Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004). Additionally, that the process of enculturation can be protective and facilitate resiliency. One study concluded that historical consciousness varies within and between AI contexts or communities in ways that need to more fully explored before clear links between negative
psychological outcomes and historical trauma can be drawn (Jervis et al., 2006). Another study established a significant and selective historical consciousness among elders, but a limited historical consciousness among younger generations. This study established that forgetting is also part of collective social memory. The findings provided evidence of how historical trauma can impact specific contexts, cultural processes, and political conditions and affect perceptions and interpretations of experiences (Goodkind et al., 2012). Denham’s 2008 study of multiple generations of one family describes that while telling stories of traumatic events from previous generations, the family incorporated the traumatic events into a framework for interpreting experiences and for achieving certain social goals. This study was one of the clearest responses to calls from scholars to focus on resilience that was articulated in the early 2000s (Balsam et al., 2004, Denham, 2008; Prussing, 2014; Walters, Mohammed, et al., 2001; Walters Simoni & Evans-Campbell, 2002). Enculturation had protective effects and facilitated resiliency (Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004).

**Discussion**

Historical trauma is a complex cumulative form of PTSD that is passed intergenerationally to descendants. PTSD symptoms are rarely measured, but the sequelae or associated affective symptoms are measured. There are several measures for historical loss thinking and associated symptoms which are still not fully developed and have good internal reliability. Measures are still needed that are valid and reliable. Historical trauma and historical loss thoughts have been found to be related to substance use including alcohol use and discrimination as a trigger for historical loss thoughts. There are different interpretations of what historical trauma is and it varies in intensity by group and probably even by individual. Some groups use the stories to build resiliency. How intergenerational transmission occurs remains unclear. It is clear that many Natives continue to experience traumatic events leading to PTSD.
Strengths and Limitations

This Literature review provides a summary of the current knowledge regarding historical trauma in American indigenous populations. The strengths of the literature review were the ability to focus on studies that specifically focused on American Indigenous populations and that most of the research has been conducted by Indigenous scholars. However, this was also one of the limitations. Additionally, the limitations were the paucity of studies on the effects of colonization/historical trauma in American Indigenous populations that are context specific. There were limited studies on colonization/historical trauma and links to alcohol use in NHs. The concept of historical trauma remains broad in scope and the attributes difficult to define and measure, specifically, how to measure the mechanisms for the intergenerational transmission of trauma experiences. There is increasing evidence that intergenerational trauma is transmitted through narratives as well as epigenetic transmission. Epigenetic transmission was not included in this literature review.

Summary of Chapter 2

The purpose of the literature review was to analyze, synthesize and evaluate the current knowledge on historical trauma in American Indigenous populations which was guided by several questions. The current knowledge on historical trauma in American Indigenous populations is broad. Most of the studies that have focused on AI populations, less on ANs and one specifically on NHs and substance abuse. The findings of the literature review underscore a somewhat limited amount of research on this concept related to vulnerable populations and exemplify the significance of conducting more research in this area that is within specific cultural contexts of individual American Indigenous groups.
Chapter 3: Research Method and Design

The pursuit of knowledge in the world we live in is universal. Natural science examines events and components of the natural world (Van Manen, 1997). Quantitative research is the primary method of natural science inquiry. The focus of quantitative research is on variables, numbers, and outcome comparisons. Social science or qualitative research focuses on studying living human beings to gain a better understanding of how we exist in our respective environments (Van Manen, 1997). Van Manen (1997), stated that using qualitative methodology is another way to conduct research. Qualitative research focuses on descriptions and meanings of participant experiences where data are analyzed inductively, and expressive language is used, and persuasion is done utilizing reasoning (Creswell, 1998). The characteristics of qualitative research include, 1) using the natural setting as a source of data, 2) using the researcher as the key instrument in the data collection process, 3) collection of data is through words or pictures, and 4) the outcomes are a product of processes rather than a product. The types of qualitative research include: 1) ethnography, 2) grounded research, 3) case studies, 4) historical, 5) hermeneutics and, 6) phenomenology. A phenomenological design is descriptive and intuitive rather than interpretive (Moustakas, 1994; Van Manen, 1997).

Phenomenology

Phenomenology has the function to describe the meaning of lived experiences of participants in a study with a focus on a specific phenomenon (Creswell, 1998). The ontological position of a phenomenological study is, 1) language is one approach to knowing reality, and 2) data is contained within the unique perspectives of the participants as expressed in their language. The research questions seek answers to the meaning of the lived experiences of human participants. Data is collected from interviews, which are then analyzed, and the statements that are extracted from the interviews are constructed into meaning clusters. The meaning clusters are
grouped together into themes to create a general description of how the phenomenon under study is experienced to gain a better understanding of the essence of the phenomenon as a whole (Creswell, 1998). This type of design allows for detailed descriptions of the essences and meanings of complex phenomena.

Initially, the philosophers who developed the foundations for phenomenology did not create discipline guidelines. Correspondingly, Van Manen (1997) developed a set of guidelines from human science research, which has served as the guide for research in nursing, law, and the social sciences. Additionally, researchers such as Colaizzi (1978); Crist and Tanner (2003); Fleming, Gaidys & Robb (2003); Koch (1996); Morse and Field (1995) and Moustakas (1994) have also contributed to the development of guidelines for research for both phenomenological and hermeneutic research traditions. In order for an inquiry to remain true to the tradition, and in keeping with the guidelines, the researcher must declare as to whether using a classical phenomenological, or a hermeneutic approach to guide a study (Annels, 1996). Thus, in keeping with this tradition, and in consideration of Indigenous ontology, and epistemology, a transcendental phenomenological research approach has been identified as the best one for this study. Chapter Three discusses the evolution of transcendental phenomenology as a methodology.

**The Evolution of Transcendental Phenomenology**

Transcendental science emerged out of increasing dissatisfaction with the philosophy of science-based solely on studies of material objects which fail to take into account the human experience and the connection between human consciousness and material objects that exist in the universe. Transcendental means to look at a phenomenon with an open mind and from a new perspective to acquire the true meaning of an experience as opposed to an explanation of a material phenomenon (Moustakas, 1994). Descartes (1970) separated the mind and the body as a
way of emphasizing the difference between bodies extended in space or objects of empirical investigation. The mind is not extended in space or a material object. Descartes questioned the reality of external perceptions that are based solely on studies of bodies or objects in space. He recognized that knowledge also emerged from self-evidence. Descartes resolved to seek no other science than "what could be found in myself" (p.119). This was a turning point for science when "philosophy turned towards subjectivity" (p.2). In other words, objective reality could only exist through representations in the mind, "objective reality is really subjective reality" (Descartes, 1977, p. 249). From a transcendental perspective, all objects of knowledge must always conform to experience or within the subjective mind of the source. Kant (1966) presented three sources of self, which include: 1) phenomena are empirically embedded in perception, 2) imagination is a necessary process and synthesizes knowledge, and 3) apperception or being conscious of the identity of objects. Accordingly, all knowledge and experiences are connected to phenomena. Additionally, a unity must exist between the knowers and the objects that are known. Descartes's (1977) knowledge, which is derived from self-evidence and Kant's (1966) transcendental beliefs regarding intuitive and apriori sources of knowledge, contributed to the development of human science. These contributions made clear that anything that is perceived or experienced by humans actually does exist and is unquestionable evidence as opposed to external objects that exist in a phenomenological sense (Moustakas, 1994). Brentano (1973) carried forward the science of phenomena and stated that "experience alone is my teacher" (p. xv). He further distinguished between natural sciences and human sciences to investigate mental phenomena, specifically perception, judgment, memory, and mental presentations. Brentano (1975) argued that "we have no right to believe that the objects that are external to us exist as they appear to us" (p.10) and that only what we know from internal perception can be counted as scientific knowledge. Husserl extended Brentano's theory regarding the intentional nature of consciousness
and the necessity for self-evidence and the value of internal perceptions and the dependence of knowledge on self-experience. Brentano's insight into the intentional character of consciousness provided the platform and vision from which Husserl's extension to transcendental phenomenology came into being. His approach is considered phenomenology because it uses data that is available to the consciousness as objects appear. It is considered transcendental because it conforms to what can be discovered through reflection on subjective experiences and their objective correlates (Moustakas, 1994). It is science because "it is logical in its assertion that the only thing we know for certain is that which appears before us in consciousness and that very fact is a guarantee of its objectivity" (Moustakas, 1994, p. 45).

Studies guided by the transcendental phenomenological philosophy developed by Husserl along with Moustakas’ (1994) Modified Stevick, Colaizzi, Keen method of analysis can empower vulnerable populations such as NHs to share their unique lived experiences of phenomena being studied. This philosophy and method provided a guide for the student researcher to be sensitive to the reality of the NH co-researchers’ experiences (Creswell, 1998). The participants are viewed as co-researchers and unique individuals who have created personal meanings from day-to-day lived experiences, which is a consideration of the phenomenological approach. It is essential to give NHs the chance to speak and to share their unique experiences through the processes of language and active listening. There are three central concepts of transcendental phenomenology, which will be discussed below.

**Three Central Concepts of Transcendental Phenomenology**

There are three principle concepts that are central to transcendental phenomenology, 1) intentionality, 2) noesis, and 3) noema. Intentionality refers to purposefully orienting the mind towards an entity and becoming intentionally conscious of it, whether or not it actually exists (Moustakas, 1994). Intuitive intentionality gives reality a presence, and the ability to perceive it
as a feature and ultimately as a whole (Moustakas, 1994). Noesis and noema are two central components of intentionality. Noesis is how it is experienced. Noema is that which is perceived and experienced. An individual's noema can vary depending on several factors, including mood, a frame of reference, or internal locus of control. Noesis and noema are viewed as two sides of a coin. Noesis the perception of a phenomenon, constitutes the textual side and noema, the meaning of the phenomenon constituting the structural side of the experience (Moustakas, 1994; Van Manen, 1997). Transcendental phenomenology has several phases and specific terms, which will be described below in order to understand the methodology of this study better.

**Phases and Definition of Transcendental Phenomenology**

The specific phases and terms used to describe the process of transcendental phenomenology are unique to this methodology. Below is a list of some standard definitions that will allow for a better understanding of the discussion of the philosophy and methodology chosen for this study.

1. **Epoche** - A Greek word that means to “abstain, stay away,” or “freedom from suppositions setting aside prej udgments, biases, preconceived beliefs,” with the purpose of deriving new knowledge and meaning about a particular phenomenon (Moustakas, 1994, p. 87).

2. **Bracketing** - the focus of the research study is placed in brackets, and everything else is set aside to allow the research process to be rooted only on the phenomenon in question (Moustakas, 1994, p. 97).

3. **Horizontalization** – a part of the process of phenomenological reduction where each phenomenon or statement is given equal value (Moustakas, 1995, p. 94).

4. **Invariant horizons or meaning units of the experience** – the nonrepetitive, nonoverlapping statements in the interview transcripts (Moustakas, 1994, p. 122).
5. Textual Description – a description of the textures of the experience, a synthesis of the invariant meaning units into themes using verbatim examples from the transcript to create clear, pictorial images of what the interviewee's experiences are during the phenomenon (Moustakas, 1994, p. 122, 133).

6. Imaginative variation – a process of seeking a variety of possible meanings by using the imagination, using differing viewpoints or perspectives or varied positions to create a structural description of an experience, "how did the experience of the phenomenon come to be what it is" (Moustakas, 1994, p. 97-98)?

7. Structural Description – a description of the structures of the experience that is derived through imaginative variation. A "vivid," account of the underlying dynamics of the experience, the themes and qualities that account for how feelings and thoughts that are connected to the phenomenon are aroused, what conditions elicit the phenomenon" (Moustakas, 1994,p. 122, 135).

In sum, this transcendental study will endeavor to broaden the understanding of colonization and historical trauma and links to alcohol use among NHs living in a rural area of Hawaii in the 21st century. This study seeks to explore the lived experiences of the co-researchers’, which are considered intertwined within a relational engagement with the world (Merleau-Ponty, 1962).

A discussion is provided of the student researcher’s role, recruitment of co-researchers, power analysis, and the projected sample size, inclusion and exclusion criteria, possible threats to internal and external validity. The procedure includes a description of informed consent, epoche, interview setting, demographic data, voluntary participation, study purpose, potential threats, benefits, methods to protect privacy and confidentiality, compensation, review of data that may be used for future research, and the opportunity to ask questions. The data collection methods
include interview methodology and data management and storage. The data analysis method includes a discussion of the Stevick-Colaizzi-Keen method of analysis, research questions, limitations, and conclusions of the study.

**Qualitative Student Researcher’s Role**

The role of the student researcher is to ensure that the methodology is appropriate for the study. Additionally, to ensure that the co-researchers are ethically recruited and that they meet the inclusion criteria and that the data are ethically managed concerning the protection of privacy and confidentiality. Also, to ensure that the measures are used correctly and that the protocol and procedures are followed, and that trustworthiness, credibility, transferability, dependability, and confirmability have been established.

**The Trustworthiness of the Study**

Quantitative research is tested for accuracy by measuring different elements of validity: 1) internal, 2) external, 3) construct validity, and 4) statistical analysis. Qualitative research is judged by different means. The trustworthiness and authenticity of a qualitative research study are determined by "naturalists equivalents," known as credibility, transferability, dependability, and confirmability (Creswell, 1998, p. 197).

**Credibility.** Qualitative credibility is equivalent to quantitative internal validity and is established through prolonged engagement, persistent fieldwork, triangulation of data, peer debriefing, member checks, or review. Prolonged engagement in the field is accomplished by developing trust with the participants by spending adequate time with them during the interview process, getting to know and understand them (Creswell, 1998). In keeping with the storytelling tradition, a time limit was not placed on the interview length. Ensuring confidentiality is another way to establish trust, which increases credibility. For the co-researchers to speak freely and to
prevent influencing the co-researchers answers during the interview, the student researcher did not comment when the co-researchers were speaking.

**Persistent observation.** Persistent observation is the process during the interviews that allows the student researcher to identify what is relevant within the purpose of the study? The process of triangulating a variety of data information sources aids the student researcher in corroborating the evidence (Morse, 1989). The data that is used to triangulate includes the interviews, observations documented in a journal right after the interviews, and demographic data.

**Member checking.** The process of member checking is critically important when establishing credibility. Member checking is attained by meeting with each co-researcher after the interviews have been transcribed and analyzed to be judged for accuracy (Creswell, 1998). The student researcher takes into account the co-researchers’ comments when completing the final analysis of the data. Member checking is an essential part of the process of a transcendental phenomenological study.

**Peer review or debriefing.** Peer review or debriefing is another means of establishing credibility (Creswell, 1998). The data is submitted to an outside researcher who can search for patterns in the data. This helps aid the student researcher to be able to look at the data from a different perspective that the outside peer researcher can help to provide alternatives to the student researchers derived conclusions.

**Transferability**

To establish transferability, a detailed description of the data is necessary. Transferability is the equivalent of external validity in quantitative research studies. Transferability allows other researchers to transfer detailed information from the study to other studies and to be able to determine if the findings are similar or the different (Creswell, 1998). As part of this study, a
detailed description of the Stevick, Colaizzi, Keen method, and the management of the data has been provided to establish transferability.

**Dependability and confirmability**

Dependability in qualitative research is the equivalent of reliability in a quantitative research study, which can be established through triangulation and journaling. Confirmability is equivalent to objectivity in a quantitative research study. Both dependability and confirmability are established through external auditing, a process where an external auditor who has no connection to the study examines the study and the outcomes to assess for accuracy (Creswell, 1998). Creswell (1998) recommends engaging in two procedures that are listed above to establish the trustworthiness of the study. The student researcher implemented prolonged engagement, detailed descriptions, peer review, and member checking in the above steps to demonstrate verification of the study findings. The analysis of the data will be considered the student researcher's interaction with the transcribed text (Fleming et al., 2003), which is a circular process, not linear, so that the co-researchers’ unique stories in context can emerge and be used for data analysis (Moustakas, 1994).

**Methods**

**Recruitment of co-researchers.** The co-researchers were selected by purposive non-probability sampling in a rural area in the State of Hawaii from August 18, 2019, until August 25, 2019. A specific rural area known to the student researcher was chosen because of the higher proportion of NH residents and because of relationships and connections that were established while residing there for two years previously. The co-researchers were given the student researcher’s contact information in the event that they might have any questions. The co-researchers were informally screened for inclusion, and exclusion criteria and those meeting the inclusion criteria were given a brief overview of the study including purpose, informed consent
(see Appendix A), the demographic data collected (Appendix B), data collection methods (audio-recorded interviews), transcription process, data storage methods, methods used to protect privacy and confidentiality, analysis procedures, and plans for future publication. The co-researchers were given a twenty-five-dollar gift card to a local pharmacy or sundry store to compensate for their time and participation before the beginning of the interviews to thank them for their time and participation.

**Power analysis and sample size.** The inclusion criteria were identified to increase the likelihood that a homogeneous sample could be obtained. Suggestions for an adequate number of phenomenology research interview participants range from 6 (Morse, 1994) to 5-25 (Creswell, 1998). The projected sample size for this study was 6 – 10 co-researchers and data saturation was reached with ten co-researchers. Six to 10 co-researchers were determined to be an adequate sample size for the following reasons, 1) the analysis was able to reveal clear interpretations of the data, 2) saturation was met with ten co-researchers, and there were no new findings with further interviews, and 3), and the narratives became redundant (Benner, 1994).

Qualitative studies typically require a smaller sample size than quantitative studies. The sample size for this study was large enough to acquire enough data to sufficiently describe the phenomenon of interest and to address the research questions. For qualitative studies, the sample size depends on several factors including, 1) the quality of data, and 2) the scope of the study, and 3) the nature of the topic, and 4) the amount of useful information obtained from each co-researcher and 5) the number of interviews per co-researcher, and 6) the use of shadowed data, and 7) the qualitative method and the study design used. There is no exact way of determining adequate sample size in qualitative research. However, the student researcher aimed to reach saturation of data by adding more co-researchers to the study until no additional information was reached. It was determined that saturation was reached with six co-researchers. Four additional
co-researchers were interviewed to achieve a sample size of ten co-researchers and to ensure that saturation of data had been reached. This was in keeping with Glaser and Strauss’ (1967) suggestion that saturation is a criterion for determining the appropriate sample size.

**Study population and the protection of human subjects.** The study population or the co-researchers consisted of adults between the ages of 30 to 60 years of age who self-identified as either part or full NH who reside or have resided most of their lives in a rural area of Hawaii. The student researcher and the principal investigator completed the Collaborative Institutional Training Institute Initiative (CITI) training for non-exempt research personnel (Appendices D & F). The co-researchers were not recruited, nor data collected until the approval letter from the IRB was received.

**Inclusion criteria.** A more homogenous sample helps reveal how experience is perceived and the meaning of that experience to a particular group (Patton, 2002). The criteria for this study included co-researchers who are: 1) NHs living in the designated rural area of Hawaii who are between the ages of 30 to 60 years old, 2) have self-identified as being NH per the definition used in this study, 3) being able to speak English, 4) willingness to have face-to-face interviews that are audio recorded, 5) willingness to speak on the topics under study, and 6) willingness to complete the demographic information, and human subject participation consent form (Appendix A).

The co-researchers were protected from undue pressure and influence by the student researcher, and they signed an informed consent (Appendix A) outlining the risks vs. benefits of the study, and that they were participating voluntarily and could withdraw consent at any time without fear of retaliation.

The inclusion criteria were developed because no qualitative studies are using the Historical Trauma Conceptual model as a guide to examine the effects of colonization and
historical trauma and links to the use of alcohol in NHs living in the designated rural area in Hawaii. Because this study targeted vulnerable population, protocol-specific safeguards were used to protect the rights and welfare of the co-researchers, which were outlined in the informed consent (Appendix A), which included the risks vs. benefits, that participation was voluntary and that they could withdraw consent at any time without repercussions. There was also the risk that a co-researcher could have become unavailable after the informed consent was signed, but before the interview, which did not occur. In case that it had, the student researcher would have notified the UH Office of Research Compliance Social and Behavioral Sciences Institutional Review Board (IRB), and all research activities with that co-researcher would have been excluded.

**Exclusion criteria.** Exclusion criteria consisted of individuals who: 1) were not from the designated rural area of Hawaii and did not self-identify as being part or full NH; 2) were under the age of 30 years of age or older than 60 years of age; 3) did not speak English or unable to communicate in conversational English. Individuals under the age of 30, and over the age of 60 were intentionally excluded because the generation between 30 and 60 years of age could reflect on their children, and grandparents' perceptions of colonization and historical trauma, and links to alcohol use over a broader period.

**Possible threats to internal and external validity.** Reliability is the process of replicability of a research study, and validity refers to the accuracy of the chosen design. Internal validity is the process of determining the extent to which the findings of a study are accurate representations of reality. External validity is determining the extent to which the findings are comparable across groups (Creswell & Creswell 2018). One threat to the internal validity of a study is the possibility of the student researcher becoming enmeshed with the co-researchers. A close relationship between the student researcher and co-researchers increases trust but can cause the student researcher not to separate her values and ideas from those of the co-researchers. A
threat to internal validity can be avoided by bracketing or mentally adding brackets around the experiences, ideas, and values of the student researcher.

Additionally, threats to external validity, applicability, and generalizability include small sample sizes. This is a common problem in qualitative studies. A threat to external validity can be avoided by completing a power analysis or following the rules for different types of qualitative studies.

**Procedure**

**Informed consent.** If the co-researcher agreed to participate in the study, the informed consent (see Appendix A) was reviewed with them before signing. The informed consent contains detailed information and includes: the voluntary nature of the study; purpose; data collection methods; potential risks, and benefits; methods to protect privacy and confidentiality; compensation, and additionally, that the de-identified data may be used for future research studies. An opportunity was provided to the co-researchers to ask questions.

**Epoche.** Before initiating the interviews, the student researcher engaged in the process of epoche or bracketing her preconceived ideas, notions, assumptions, and beliefs about colonization and historical trauma and links to the use of alcohol with the NH co-researchers. The student researcher has experienced the phenomenon under study as part of growing up Cherokee in a Cherokee family. The student researcher had to set aside the assumption that NHs have experienced similar experiences and be able to listen to their stories without judgment and presuppositions. Before meeting with each co-researcher, the student researcher reflected and cleared her mind to prepare for each of the interviews. Additionally, the student researcher wrote an in-depth self-reflective journal during the data collection phase in accordance with Creswell and Creswell (2018) and Moustakas, 1994).
Interview setting. When a co-researcher agreed to participate in the study, a time and place were selected to meet. The student researcher conducted private face-to-face interviews at a mutually agreed upon private, comfortable, and quiet location. No time restraints were placed on the interviews to allow the co-researchers as long as needed to tell their stories. The interviews lasted from 40 minutes to 80 minutes. The average interview lasted 60 minutes. The student researcher began each interview by creating a trusting, quiet, and private environment and allowed the co-researchers to speak freely and openly. The student researcher reviewed the informed consent and agreement to participate (Appendix A) and the Demographic Data Sheet with the interview protocol and research questions (Appendix C) with the co-researchers. Upon the completion of the consent form and demographic questionnaire, the student researcher began to record the interviews. The student researcher asked the research questions, and the co-researchers used the interview protocol as a guideline. When the interviews were concluded, the student researcher informed the co-researchers that once the interviews were analyzed, there would be a follow-up encounter if they desired to allow the co-researcher to read the analysis of her interview and allow them to edit it as necessary.

Demographic Data. Demographic data (Appendix B) was collected from each of the co-researchers. The co-researchers were asked to complete the demographic questionnaire after they signed the informed consent form (Appendix A) and before beginning the interview. The demographic data were collected in order to describe the co-researchers in the study.

Voluntary participation. The informed consent (Appendix A) gave a brief introduction of the student researcher, the program of study, and explains what the co-researchers are being asked to do. It also informs them that their participation in the study is entirely voluntary and that they may stop participating at any time without any penalty.
**Review of the study purpose.** The informed consent (Appendix A) explains the purpose of the study, and why the study is being done, which rural area the co-researchers are being recruited from, and explains why they were chosen as a co-researcher for the study.

**Review of potential threats.** The informed consent (Appendix A) reviewed the possible risks for participating in this research study and advised the co-researchers of their options if they become uncomfortable during the interview such as, a) skipping a question or taking a break or, b) stopping the interview, or c) withdrawing from the study entirely. It also advised the co-researchers where they could seek support if they become emotionally upset from participating in the study. It also offered the co-researchers an opportunity to review a summary of the results of the study upon completion if they desired by contacting the student researcher.

**Review of benefits.** The informed consent (Appendix A) informed the co-researchers that there would be no direct benefit to them for participating in the study and that the results of this research study may help to enlighten the NH population of the consequences of colonization and historical trauma and links to alcohol use, and potentially to decrease the use of alcohol in NHs and to improve their health to benefit future generations.

**Review of methods to protect privacy and confidentiality.** Informed consent (Appendix A) described the procedures that were used to protect the co-researchers' privacy and confidentiality. The co-researchers were asked to share only the information that they felt comfortable sharing. They were also informed of who would receive and use their information. The co-researchers were informed that confidentiality of their information will be preserved, and not divulged to others without their permission other than in the way it was defined in the informed consent (Appendix A).

The co-researchers were informed that the data collected, demographic data, audio recordings, and transcripts were de-identified, and their names were replaced with an alias,
which will be used as an identifier. The co-researchers were informed that when the results of the research study are reported, none of their personal identifying information will be used. The findings will be reported in a way that protects the co-researchers' privacy and confidentiality to the extent allowed by law. The co-researchers were advised that the informed consent (Appendix A), and the demographic data sheet (Appendix B), audio recordings, and transcripts will be safeguarded in a locked filing cabinet in the student researcher's home, and on a password-protected computer, and that after one year the audio-recordings will be destroyed.

**Review of compensation.** The informed consent (Appendix A) informed the co-researchers that they would be compensated for their participation in the study with a $25 gift card to a local pharmacy or sundry store at the beginning of the interview.

**Review of Data that may be used for Future Research.** The informed consent (see Appendix A) informed the co-researchers that their de-identified data might be used for future research studies without further consent, approval, or financial compensation.

**Opportunity for questions.** Informed consent (Appendix A) instructed the co-researchers that they would be allowed to ask questions before signing it. The consent also provided contact information for the student researcher and if they think of any questions at a later time or want to discuss any concerns, questions, or acquire information. The co-researchers were given a signed copy of the informed consent (Appendix A) for their records.

**Data collection methods.** The co-researchers were asked to complete a demographic data sheet (Appendix B), and that the demographic datasheet will be stored separately from the informed consent (Appendix A). The co-researchers were assigned a pseudonym in place of their real name as an identifier to be used on the demographic data sheet (Appendix B), the audio recording, and transcribed interviews.
**Interview methodology.** The data was collected in a one-time interview using the co-researchers' pseudonym as the identifier with open-ended questions that allowed the narratives/stories to lead in order to gather experiences with colonization and historical trauma, and how they have coped, positively, and negatively, and how alcohol is used today. No clock time was suggested to honor the storytelling tradition. There was a natural break, which was based on the flow of the stories for relaxation and nourishment as needed by the co-researcher when indicated. The co-researchers were informed that any information that is shared would remain confidential. Before the interview, the student researcher bracketed out her own experiences of the phenomenon of colonization, historical trauma, and alcohol use by setting aside presuppositions. This assisted the student researcher in creating an unbiased atmosphere.

The study was conducted at a mutually acceptable location. An interview guide with open-ended questions (Appendix C) was provided to help focus the interviews on the phenomena under study. The co-researchers were assessed throughout the interviews for signs of psychological, and emotional concerns, and by observation of the outward expression of mood, including eye contact, body language, thought processes, patterns of speech, and responses. After the interviews, the co-researchers were allowed to debrief as needed. Additionally, after the interviews were completed, the audio recordings were reviewed with the co-researchers and were later transcribed in preparation for analysis.

**Data management and storage.** The student researcher had the audio tapes transcribed by NVivo Transcription. The interviews are stored as audio files on the researcher's hard drive in her home office, which is password-protected, and only the student researcher has access to the computer and audio files. Upon receipt of the transcriptions, the student researcher first listened to the interviews while reviewing the transcription to ensure the accuracy of the transcription.
Data Analysis Method

The Modified Stevick-Colaizzi-Keen method of analysis. Moustakas' Stevick-Colaizzi-Keen method of transcendental phenomenology method appealed to the student researcher because this method recognizes the influence and impact of the student researcher's own lived experiences of the phenomenon under study and allows the student researcher to acknowledge her own experiences. The background of the student researcher has been provided. A brief description of Moustakas' Modified Stevick-Colaizzi-Keen method of inquiry is detailed below. "Each statement was considered with respect to significance for a description of the textures of the experience including verbatim samples,

1. The student researcher has provided a full description of her own experience with the phenomenon under study.
   a) record and consider all relevant statements,
   b) list each nonrepetitive, nonoverlapping statement as these are the invariant horizons or meaning units of the experience,
   c) relate and cluster the invariant meaning units into themes,
   d) synthesize the invariant meaning units and themes into a description of the textures of the experience including verbatim examples,
   e) The student researcher will reflect on her textual description and through imaginative variation, construct a description of the structures of the experience,
   f) The student researcher constructed a textual-structural description of the meanings and essences of her own experience through imaginative variation.

1. From the verbatim transcript of the experiences of each of the other co-researchers, complete steps, a through f.
2. From the individual textual-structural descriptions of all co-researchers' experiences, construct a composite textual-structural description of the meanings and the essences of the experience integrating all individual textual-structural descriptions into a universal description of the experience represented as a whole.” (Moustakas, 1994, p. 123).

Research Questions

1) What do you know about the history of the State of Hawaii, and are there any stories that have been passed down in the area you live in since the arrival of Captain Cook in 1778?

2) What do you know about the health of Native Hawaiians as compared to other ethnic groups living in Hawaii today?

3) What do you know about the Native Hawaiian health status when Captain Cook arrived in Hawaii compared to the health status of Native Hawaiians now?

4) What do you know about alcohol use by Native Hawaiians in your area currently?

5) Have the kupuna ever talked about alcohol usage when they were growing up?

6) Have you ever heard anyone use the word "colonization," and if so, what does it mean to you?

7) Have you ever heard of the words "historical trauma," and if so, what does that mean to you?

Limitations of the Study

The possible limitations of this study were that it was a qualitative study conducted in a small, relatively isolated area in Hawaii. Additionally, because the study was qualitative, the sample size was small, a total of ten co-researchers and the student researcher. Another limitation was that the student researcher either knew or was known to the co-researchers who participated in the study after having lived in the area for two years. Additionally, the student researcher has also experienced the phenomenon under study, which is one of the primary reasons for the
selection of the methodology used in the study since it incorporates the student researcher’s experiences along with those of the co-researchers. The previous limitations which were considered as possibilities included, a) challenges with IRB approval, b) difficulty gaining access to the targeted population, c) reluctance of NHs who use alcohol to self-identify for fear of stigmatization in the small rural community and d) time limitations which did not present as limitations.

**Chapter 3 Summary**

Chapter 3 presents the research design and proposal used for this research study. A brief description of naturalistic inquiry and human science are discussed. The evolution of human science is presented, including a description of phenomenology, which falls under the umbrella of human science was discussed. The evolution of transcendental phenomenology, a type of phenomenology, was presented and discussed along with the three central concepts of transcendental phenomenology, which include 1) intentionality, 2) noema, and 3) noesis. Additionally, the phases and definitions of transcendental phenomenology were presented and explained. The qualitative student researcher's role was discussed, including the establishment of the trustworthiness of the study, including the components of, 1) credibility, 2) persistent observation, 3) member checking, 4) peer review or debriefing, and transferability, and 5) dependability and confirmability.

The transcendental phenomenological method, the Modified Stevick-Colaizzi-Keen method was discussed including, 1) the recruitment of the co-researchers, 2) power analysis and sample size, 3) study population and protection of human subjects, 4) inclusion criteria, exclusion criteria, 5) possible threats to internal and external validity. The procedures were presented as follows, 1) informed consent, 2), epoche, 3) interview setting, 4) demographic data, 5) voluntary participation, 6) review of the study purpose, 7) review of potential threats, 8)
review of benefits, 9) review of the method to protect privacy and confidentiality, 10) review of compensation, 11) review of data that may be used for future research, 12) opportunity for questions, 13) data collection methods, 14) interview methodology, and 15) data management and storage, and 16) lastly, the data management method. Finally the specific steps of the Modified Stevick-Colaizzi-Keen method was discussed along with the research questions that were presented to the co-researchers.
Chapter 4: Findings

Chapter 4 presents the findings of this research study. A description of the site of the study, the co-researchers, the results of establishing trustworthiness is discussed. Additionally, a complete description of the results of the data analysis using Moustakas' (1994) Modified Stevick-Colaizzi-Keen method of transcendental phenomenological data analysis and reduction is presented. Each stage is discussed, including a summary of the chapter.

Site Description

The ten interviews were conducted in a specific rural area in Hawaii, which will remain anonymous in order to protect the identities of the co-researchers. The co-researchers selected the interview sites. Seven were interviewed at their private residences, one was interviewed in a secluded area at a local park, one was interviewed in a secluded area at a local park, and one was interviewed in a private area of a local restaurant. In advance of the interviews, the co-researchers were provided with a copy of the informed consent (Appendix A) and the interview guide (Appendix C). The informed consent (Appendix A) was reviewed in detail with the co-researchers in the presence of the student researcher. The student researcher then answered questions and offered clarification of information about the research study. Each co-researcher was given the option of proceeding with the interview. After the co-researchers signed the consent form (Appendix A), the interviews proceeded and were audiotaped. The co-researchers were offered the opportunity to conduct a follow-up interview and the opportunity to review the transcripts before analysis in order to provide direction to modify the information if needed. Contact information for the student researcher was provided so that the co-researchers could contact her if they wished. Analysis began after the commencement and transcription of each interview. Saturation was reached after the transcriptions of six of the transcripts (Moustakas,
1994). Four more interviews were conducted, all of which yielded similar results. Recruitment ended with a total of ten co-researchers.

Description of the Co-Researchers

The student researcher chose Moustakas' (1994) Modified Stevick-Colaizzi-Keen method instead of the Van Kaam method for data reduction and analysis. Moustakas' (1994) postulated that it is important for the student researcher to have experienced the phenomenon under study for this method of analysis. In keeping with the method, the student researcher was the first informant to contribute to the study. The student researcher deemed this method as appropriate because her personal story fits the research questions under investigation and the sample criteria. The other participants are considered as co-researchers. The overarching goal of this method is that the results of the study outcomes, including the student researcher's and the co-researchers’ experiences will connect and represent the group as a whole (Husserl, 1931). The concepts of noesis and noema, which will be discussed in detail below. All of the co-researchers in the study described the same phenomena from their perspectives. Before data was collected, the student researcher practiced epoche or bracketing, the processing of describing her own experiences in relationship to the phenomenon of the study. This technique increases the student researcher's awareness of any underlying feelings or biases regarding the research topic. Through this process, the student researcher relinquished all presuppositions and biases and was able to look at the topic with an unbiased perspective as the co-researchers’ told their stories.

Purposeful direct recruiting was used throughout a rural Hawaiian community to recruit the co-researchers who self-identified as either part or full Native Hawaiian. All were between the ages of 30 to 60 years of age and were interested and willing to participate in the study. There were a total of ten co-researchers, eight females, and two males, not including the student researcher. Counting the student researcher as one of the co-researchers increased the number to
eleven. The co-researchers were agreeable to being assigned pseudonyms from co-researcher one through ten.

Table 7: Demographic Characteristics of the Sample

<table>
<thead>
<tr>
<th>Characteristics</th>
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<tbody>
<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<tr>
<td>Age (in Years)</td>
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<td>30-39</td>
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<td>Retired</td>
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Results of Establishing Trustworthiness
The trustworthiness of the study was established by using credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was achieved by the student researcher who lived in the community for two years and had developed trusting and meaningful relationships with many people. Persistent observation began with each transcript. Each transcript was reviewed many times to determine the unchanging horizons and the invariant constituents and to identify the major core themes. The process of triangulation was achieved by comparing the co-researchers’ transcripts to one another and to the literature review.

Additionally, contextual validation was aided by accomplishing credibility. Member checking was conducted, which included time for the co-researchers to process the experience and for the student researcher to verbally summarize the interviews and ask questions for clarification. Each co-researcher confirmed the information as accurate. A summary of previous interviews was shared with each subsequent co-researcher if they wished. All of the co-researchers identified with the summaries and felt that they had shared very similar experiences. Transferability was determined from the descriptions of the data collected and transcribed from the interviews. The student researcher kept a complete record of the raw data, the reduction of the data, the results of the analysis, the reconstruction of the data, and synthesis of the data in order to establish dependability and confirmability.

**Moustakas’ (1994) Stevick-Colaizzi-Keen Methodology**

**Phenomenological Data Reduction**

Moustakas' (1994) modification of the Stevick-Colaizzi-Keen method of phenomenological data reduction requires that the student researcher use imaginative variation to construct individual textural and structural descriptions from each of the ten co-researchers’ interviews including the student researcher's self-interview. The process of phenomenological reduction began with identifying the unchanging horizons or invariant constituents in each of the
interviews or stories. This process led to descriptions of the essential textures or perspectives in each story. The textual descriptions evoked clear images of what each co-researcher was experiencing, remembering, feeling, thinking, and judging during the process of storytelling. Through the process of application validation described by Moustakas (1994), the invariant constituents or unchanging horizons were compared to each of the transcripts. This step was completed in order to verify that the statements had been clearly expressed by each co-researcher and were relevant to their experiences. The individual structural descriptions were constructed from the components connected to the universals of time, space, bodily concerns, materiality, causality, and relation to self and relation to others. Lastly, the individual textural and structural descriptions were integrated into a universal composite textural-structural description, which is representative of all of the co-researchers in the study. The results of the data analysis, including the individual textural and structural descriptions and the composite textural-structural description of the phenomena, are presented below.

The results of the analysis were determined by processing the data through the stages of Moustakas’ (1994) Modified Stevick-Colaizzi-Keen method. The steps of the method included: 1) first, the completion of a transcript of the student researcher’s experiences of the phenomenon under study, and 2) the following steps were then initiated from the verbatim transcript of the student researcher, a) each statement within the transcript was considered concerning the significance of the phenomenon under study, b) all of the relevant statements identified as a non-repetitive, non-overlapping statements, invariant constituents or unchanging horizons were identified, c) each non-repetitive, non-overlapping statement or invariant constituent or unchanging horizon was recorded, d) each of the non-repetitive, non-overlapping statements, invariant constituents or unchanging horizons were clustered into themes, e) the themes were synthesized from the textures of the experience from the student researcher’s verbatim dialogue,
f) the student researcher reflected upon her textual description or experiences, and g) a
description was constructed of her textual-structural description of the phenomenon under study,
and 3) after the above steps were completed the transcripts of each of the co-researchers were
processed through the same steps.

The initial steps of the analysis included: 1) epoche or bracketing, 2) reduction of the data
including, a) horizontalization or the determination of the unchanging horizons, b) identification
and clustering of core themes and c) the construction of core themes using verbatim dialogue
from the co-researchers’ stories. The final steps of the analysis included the synthesis of
meanings incorporating the concepts of intentionality, noesis, and noema. These steps included,
1) construction of individual textual descriptions from the stories of the co-researchers, 2)
construction of an individual composite description from the stories of the co-researchers, 3)
construction of individual structural descriptions underlying the co-researchers’ experiences,
including the following structures, a) universal structure of time, b) universal structure of space,
c) universal structure of bodily concerns, d) universal structure of materiality, e) universal
structure of causality, f) universal structure of self-in-relation, and g) universal structure of
relation-to-others, and finally 4) the synthesis of meanings and the construction of a universal or
a composite textural and structural description of the co-researchers’ experiences. The composite
textural-structural description was completed through the process of imaginative variation by
synthesizing and integrating the individual textual-structural descriptions into a universal or
composite description of the co-researchers’ experiences represented as a whole (Moustakas,
1994, p. 123). The codes in the diagram below represent the unchanging horizons, invariant
constituents, or meaning units from the stories.
Epoche or Bracketing

Before each interview, the student researcher reflected at great length on setting aside pre-existing beliefs or presuppositions regarding NHs lived experiences and perceptions of colonization and historical trauma and links to the use of alcohol use. The student researcher 'bracketed' the topic and her personal experiences of the phenomenon. The process required making a substantial focused and conscious effort to remain present and to remain receptive to the NH co-researchers’ stories as they unfolded. Many of the co-researchers were aware of the student researcher’s experiences of the phenomenon under study before agreeing to the interviews. When any pre-existing belief or presuppositions entered the student researcher’s mind during the co-researchers’ stories, the student researcher refocused on the epoche process and the research question. This allowed the student researcher to focus on observing what emerged in the co-researchers’ stories as their stories unfolded.

Reduction of the Data
**Horizontalization or the determination of the unchanging horizons.** During the process of horizontalization, each transcript was reviewed numerous times, and each statement was given equal value. All relevant statements were recorded. The horizons were identified, and every non-repetitive, non-overlapping expression or horizon that was relevant to the phenomenon under study was preliminarily grouped into horizons, constituents, or meaning units (Moustakas, 1994). The student researcher preliminarily reviewed the non-repetitive, non-overlapping statements or unchanging horizons and tested each one for having an essential experience that could be satisfactorily understood. Also, to be able to determine if the horizon or expression could be abstracted and labeled. If the horizon or expression met these conditions, it was considered to be an unchanging horizon, an invariant constituent, or a meaning unit. Any statement that did not meet these conditions was eliminated along with any repetitive or ambiguous expressions or statements. The unchanging horizons that remained after this process of reduction were considered to be invariant constituents or unchanging horizons of the experience (Moustakas, 1994).

**Identification and clustering of core themes.** Five major, broad core themes emerged from all of the co-researchers’ experiences. The core themes were identified as a result of the process of clustering the invariant constituents or the unchanging horizons into thematic labels (Moustakas, 1994). The themes include, 1) unresolved grief over losses which was the most universal theme that the co-researchers described in their unfolding stories, 2) excellent health before to the worst health after colonization was the second most universal theme the co-researchers described of the five themes in their unfolding stories, 3) alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination was the third most universal theme that the co-researchers described in their unfolding stories, 4) the kupuna teach the younger NHs to drink alcohol was the fourth most
universal theme that the co-researchers described in their unfolding stories, and 5) understanding the impact of colonization and historical trauma was the fifth most universal theme that the co-researchers described in their unfolding stories. Verbatim examples of the dialogue from each of the co-researchers’ storytelling interviews, including the student researchers are provided as they relate to the emerging themes identified in Appendix G.

**Construction of Individual Textual Descriptions from Stories of the Co-Researchers**

The student researcher used the relevant invariant constituents or the unchanging horizons and the core themes to construct the individual textual description for each of the co-researchers’ and the student researcher. The textural descriptions and perceptions (noesis) of the phenomena (noema) under study constitute the textural side of their experiences or the *what* that the co-researchers experienced. The individual textural descriptions elicit a clear picture of the co-researcher’s experience.

Self-interview: The experience of colonization, historical trauma, and alcohol use in my family was set in motion when European explorers arrived in the Cherokee homelands. White settlers encroached on and forcibly took away Cherokee lands when they were found to have value to them. There were many broken treaty promises with the U. S. government. Ninety-five percent of American Indigenous populations died from the spread of infectious diseases. Small Pox was spread with the deliberate intent of killing Alis. Alcohol was also deliberately introduced and used as a tool to colonize and take Indigenous lands. The student researcher grew up in a Cherokee family. As a child, the student researcher experienced and accepted alcoholism, domestic violence, and poverty as being a normal part of life. Most of the student researcher’s family history was lost after the Trail of Tears. The legacy of alcohol, which was started in the early days of colonization, continues and remains a destructive force in the family, continuing to affect everyone on some level. Some of the student researcher’s family use alcohol as a means to
cover up feelings of losses and poverty. Today, there are proximal or immediate problems with other drugs such as methamphetamine and opioids.

Like most Cherokee, the student researcher’s family was assimilated into the lowest economic strata. Cherokee people, like other Indigenous people, suffer from chronic diseases today. Like NHs and some other AI groups, the Cherokee have had a renaissance. Cherokee culture and language are being taught today. Cherokee Nation owns twelve casinos, which has a two-billion-dollar economic impact on the Oklahoma economy. Cherokee Nation provides education, health care, and other assistance to members of the tribe. They are buying back some Cherokee lands in Oklahoma. Cherokee Nation is considered one of the largest tribes in the country. Most Cherokee are of mixed heritage. There are relatively few full-bloods left. The student researcher feels that if blood quantum were a measure of being Cherokee, there would be far fewer Cherokees today.

Co-researcher 1’s experiences of colonization and historical trauma focused on the loss of land, as did the other co-researchers. For co-researcher 1, the land that the airport is built on serves as a frequent reminder of loss. He feels hopeless about the possibility of his family regaining the land even though their family members are looking at legal claims to it. He talked about the loss of good health for NHs. He recognizes that there have been significant dietary changes for NHs, which had led to the development of chronic diseases that did not exist before colonization happened. He feels sad about the loss of culture and language but did not learn about NH history while in school. He wants to learn about NH history as it really happened in order to understand more fully the impact that colonization has had on NH people. From his experience, alcohol use in his family is not a problem. Alcohol use is managed well at family gatherings and celebrations. He recognizes and feels sad about the influx of methamphetamine into the islands and how it is a problem for the Hawaiian people today. Co-researcher 1 feels
fortunate that the kupuna in his family educated him at a young age not to touch methamphetamine. Even though he did not recognize the words colonization or historical trauma; he knew the impact of both and discussed what is happening on Mauna Kea today. He expressed that the building of another telescope is a critical issue to him. The spiritual importance of the mountain as part of his culture and heritage is essential to him. The interview piqued his curiosity about NH history and the impact of colonization on the NH people. He expressed that he wants to learn more about what happened to his people after the arrival of Captain Cook.

Co-researcher 2’s experiences of colonization and historical trauma focused on the catastrophic losses of NH people to infectious diseases after Captain Cook arrived in Hawaii. She expressed sadness over lost lands, language, and culture that resulted from Westerners colonizing the islands. Co-researcher 2 felt that everything was taken from them against their will when the Hawaiians monarchy was overthrown. She expressed feeling that Hawaii should not be a part of the United States. She continues to think about and grieve the loss of lands that were given to her family by King Kamehameha III during the Great Mahele in 1839. Co-researcher 2 feels that the Western practitioners at the local community health center do not care about NH health. She expressed that Western medicine is part of the process of trying to do further harm to NHs and to take the rest of the land. The Western way of owning land and of not sharing is not like the NH way where resources were shared. One of her fears is what is happening on Oahu, the overdevelopment and overcrowding will happen in her area.

Co-researcher 2 expressed being concerned that NH people overindulge in unhealthy foods and eat poorly. Many foods cause diabetes and other chronic health issues. Also, that NH people overindulge in alcohol. She pays attention to what she eats and manages her weight.
Despite eating right and exercising she has borderline diabetes. She expressed that she would like to see NHs take better care of themselves. Before Westerners arrived, NHs were healthy.

Co-researcher 2's early experiences of alcohol was that drinking was considered the norm in the 1950s. She witnessed domestic violence, which was common at the time. Her experience was seeing husbands become intoxicated and hit their wives. Because she witnessed domestic violence growing up, she would never drink alcohol herself and that NHs cannot handle alcohol. Also, she did not marry a man who drank or who was abusive. She witnessed both of her grandfather’s drinking alcohol. Today her experience is that many young Hawaiians drink, abuse their girlfriends, make a lot of wrong choices, and have legal problems. She is teaching her sons and other family members not to drink alcohol because it is destructive to NH families and the community. She describes alcohol as a choice. Co-researcher 2 expressed that many NH people drink because of the losses they have experienced. She made the point that alcohol and trading in rum were involved when NH lands were taken away in the late 19th century. Alcohol use and the laws that regulated it led to the NH Queen being overthrown and having to live by a different set of rules. She was undecided as to whether colonization was a good or a bad thing. She feels that being part of the U.S had some benefits but did not elaborate on what those benefits are for her.

One significant trigger for historical trauma is the memory of singing the song 'Ten Little Indians' in school. She remembers that her grandmother would get upset when they sang this song. She did not understand at the time why her grandmother would get upset. Then she realized that the song was about killing Indians. The memory of this continues to upset her today.

Co-researcher 3’s experiences of colonization and historical trauma focused on the loss of lands, language, and religion and of Westerners trying to make NHs adopt Christianity in order to acculturate them and to eliminate Hawaiian culture. She has begun the process of learning the Hawaiian language and NH culture. Because she works in the health industry, she recognized
that NHs have chronic health problems and suffer from high rates of diabetes, obesity, high blood pressure, and heart disease, which has to do with high-fat foods eaten at family gatherings and celebrations. Co-researcher 3 feels that NH health is a big industry; dialysis is a big industry secondary to diabetes and kidney disease. She feels that mainlanders introduced fast foods, which has led to poor health of the NH people. Her understanding is that the full blood NHs who live on Niihau are still healthy because they limit who can go to the island. However, if NHs living there develop diabetes or hypertension, they have to leave the Niihau and go to Kauai or Oahu for health care since they are the closest islands.

Co-researcher 3's mother's side of the family has many alcoholics. As a child, she was surrounded by drinking, music, and celebrations. Her first experience with alcohol occurred when she was thirteen. Her mother let her have wine, but did not allow her to become intoxicated. Her mother required that she be able to manage drinking alcohol without becoming intoxicated. Co-researcher 3's experience is that a lot of Hawaiians like to drink alcohol on weekends during football games. Alcohol is always part of the celebrations, and she feels that this is why there are many alcoholics, including DUIs and people killed as a result of drinking alcohol. Co-researcher 3 teaches her children when to stop drinking alcohol.

Additionally, she experiences discrimination in her community. Co-researcher 3 feels that discrimination affects NH men the most and that they try to cope with discrimination by using alcohol or methamphetamine. She recently lost her fiancée because of methamphetamine use. He had used methamphetamine for most of his life. She expressed that he had experienced a bad upbringing, and had dealt with a lot of personal demons. Co-researcher 3 feels that alcohol and drugs started because of the loss of identity, which is a consequence of colonization. "When your identity is stripped away, it brings down your self-esteem." Today she continues to struggle to feel worthy, that she is a good person, and finds it challenging to maintain a good self-esteem.
and self-image. She experienced discrimination when she started her nursing career and experienced people assuming that she was not intelligent or was lazy because she is NH. It was her experience that if "you are not White or Oriental, then you are a nobody." She felt that she could relate to what African Americans, Mexicans, and AI people go through. Co-researcher 3's experience is that NHs have to work harder to prove who they are and to prove that they are worthy.

Co-researcher 4’s experiences of colonization and historical trauma have focused on many changes in the lifestyle of the NH people. He understood that before Captain Cook arrived the governmental structure was a monarchy with one million NHs living in Hawaii. He felt that the Western style of governing was slowly ingrained into the Hawaiian monarchy, which led to the monarchy being overthrown. Co-researcher 4 felt that it was the ingraining of a Western-style government that ruined the NH culture. He felt that NH history was not truthfully told which made the people susceptible to accepting Western ways. The missionaries brought Christianity to Hawaii, which was adopted by some NHs. Co-researcher 4 expressed it is his feeling that the NH genocide continued as a consequence of being forbidden to speak the NH language because Westerners disagree with NH culture. He felt that the U.S. was trying to kill the people and kill the culture. Co-researcher 4 believes that NHs should learn their history and to learn the truth about what happened to the people. His family advised him to follow Christian traditions. He felt that it is better to follow Christian ways because the old NH ways were about acquiring power. He feels that in this way it is better the way it is now.

Co-researcher 4’s understanding is that Captain Cook and other Westerners brought infectious diseases to NHs. Before Western contact, NHs were strong, healthy, without disease, and working hard on the land. The majority of the NH population died as a result of infectious diseases. Today, NHs have more chronic diseases, including high blood pressure, diabetes, heart
disease, cancer, and asthma, and are susceptible to chronic diseases because they are not active as compared to other ethnic groups like people living in, for example, Norway as he expressed in the interview.

Co-researcher 4 was knowledgeable about NHs use of alcohol. Alcohol was the substance most used until methamphetamine arrived in Hawaii. Before methamphetamine, NHs used cocaine and continued to drink heavily. His experience is that NHs are switching to methamphetamine as the substance of choice. Co-researcher 4 used cocaine, alcohol, and methamphetamine in the past but stated that he has been clean for many years. NHs who were once alcoholics will not go back to alcohol use only because methamphetamine has more powerful effects, is more addictive and cheaper, and "gives a better high." Methamphetamine is shipped directly to homes by Federal Express and the U.S. Postal Service from Mexico.

Co-researcher 4's experience of colonization and historical trauma was the U.S. and the changing and eliminating of NH history and people. He feels that it is a way to stop NHs from learning the truth about what happened and that demands continue to be made for NHs to learn Western ways. An example of his current experience is the conflict on Mauna Kea and the building of another telescope on sacred lands. He expressed that it is painful and offensive to NHs when a load of dirt is removed from their mountain. Excavation and removing of the dirt is unearthing and removing the bones and ashes of the ancestors buried on the mountain. Also, there is a table of freshwater on the mountain that has the potential to sustain the people for a long time. Co-researcher 4 feels that this is the actual reason that there is controversy. It is his understanding that in order to operate the telescope, nuclear power would be needed. This would require the use of the water, which would contaminate it with nuclear waste. The fight is political. NH people never gave consent to build on Mauna Kea. Co-researcher 4 feels that the Department of Hawaiian Homelands (DHL) and the University of Hawaii (UH) previously
allowed thirteen telescopes to be built without consent from NHs and that they created and used back-door policies. He feels that a spiritual process is exposing "the lies, the crooks, the dirty politicians, and the illegal acts of the past.” NHs are resilient and are in school learning Western laws and using this knowledge to fight in the courts to block the building of the telescope on Mauna Kea.

Co-researcher 5’s experience of colonization and historical trauma is that NHs used to have a lot of land and resources available to them. She expressed sadness that the Hawaiian lifestyle has changed for the worse. Many families are broken two centuries later. In the past, NHs did not own property. They did not have to own property or have high rents or mortgages. She feels that Westerners keep taking from NHs. The taking of lands and resources has occurred for generations. Today it is the building of a telescope on Mauna Kea. She feels that NHs lost their land because others took it and then they said, “to get out, you are on my land and I don't want you here anymore," Her family had lived on the land for generations. She expressed that NHs died from infectious diseases after first contact with Westerners. Today NHs are sick from diabetes, cancer, heart disease, and high blood pressure. She feels that NHs are susceptible to chronic diseases and have the worst health of other ethnic groups in Hawaii. NHs used to have access to healthier food and had good health. Co-researcher 5 feels that NHs were better off before Captain Cook came. She finds it hard to watch the news because of the homelessness and drug use among NHs. She expressed concerns that mental health is ignored in NHs, which is also the result of colonization and historical trauma. That it is a continuing cycle that does not end and keeps getting worse and wonders, "when is it going to stop happening?"

Co-researcher 5 feels that alcohol is a significant problem among NHs and that many people do not know "when they've had enough to drink," and the police or an authority have to intervene. Her experience is that the younger generation of NHs are the most affected by alcohol
and that it is painful to observe. Co-researcher 5 took a stand in her family not to drink alcohol. She uses the excuse that she is allergic to alcohol with her family to avoid peer pressure to drink. She is trying to be a role model and set a positive change. Her concern is that the younger generation is like, the older generation or the kupuna in how they drink. She also expressed that methamphetamine use is a problem. Her concern is that methamphetamine use in the younger generation is out of control almost as much as alcohol use. Co-researcher 5 expressed fear that once marijuana is legalized, there will not be a way for NHs to recover from alcohol and drug addiction. She would like to see all alcohol and drugs eliminated but feels that once any drug is legalized, they are here to stay. Alcohol was a significant issue before, but now methamphetamine is a bigger problem. Co-researcher 5 feels that NHs are self-medicating with drugs and alcohol from the losses, both past, and present. She feels that no one has cared about NHs and the impact that alcohol had on them. She feels that NH research thus far has only focused on diet and chronic disease rather than including studies on mental health, alcohol and other drug use. She feels frustrated that the U.S does not care about managing alcohol use in NHs because they have gained control of the land. She expressed concern that the NHs who are part of the military suffer from PTSD experience another level of trauma. She feels that they self-medicate by using marijuana, methamphetamine, and drinking alcohol.

Co-researcher 5 feels that the kupunas have taught the younger generations to drink alcohol and expressed concerns because she continues to see them drinking. "It's what our kupunas are doing." She described how her mother and father drank alcohol and how they did not consider alcohol a problem. She feels that alcohol destroyed her family. The men who drank alcohol hit their wives and often went to jail for domestic violence. Young kids are using alcohol and methamphetamine in schools. Co-researcher 5 feels that the kids "are broken because of it."
Co-researcher 6’s experience of colonization and historical trauma was the loss of people. The loss of approximately one million NHs as a result of infectious diseases that were introduced by Westerners after contact. She feels that "things were ruined" for NHs. They were not allowed to speak their language, practice cultural traditions, and the land was taken. Today you have to buy land or wait to get homeland property. Many NHs never get homeland property and remain on waiting lists for years. The land is expensive, and there are not that many places to work in her area, making it more challenging to pay a mortgage or rent. Her experience is that many of the younger generations have to leave the area because they are unable to find jobs near home. Many go to other islands or the mainland. Mainlanders who can afford to buy expensive property buy expensive homes and often do not stay because it is not what they expected to find. Co-researcher 6 feels that NHs are not better off in terms of health. NHs suffer from chronic diseases such as diabetes, cancer, heart disease, and high blood pressure. Chronic diseases did not exist before Captain Cook arrived. She feels that none of these chronic diseases would exist if not for colonization. NHs used to have good health but today have the worst health of all other ethnic groups in Hawaii.

Co-researcher 6 feels that many NH families have problems with alcohol and are unable to control how they use it. She expressed concerns that there are domestic violence issues that stem from alcohol use and that the authorities get involved. Many NH people go to jail. She feels that young NHs are like the kupuna whom she feels have a habit of drinking and are teaching younger NHs to drink. Alcohol is not considered a problem in her family where it is normal to drink, but alcohol has caused many problems for her family. Many are alcoholics. She feels that many drink alcohol to numb feelings of discrimination, and because of all of the losses. Co-researcher 6 expressed the feeling that NHs are looked down on by other ethnic groups in Hawaii, and there is much discrimination. She feels that discrimination is the reason that there is
also, a lot of methamphetamine use and, that methamphetamine is used as much as alcohol. Both are problems in the community, and NHs never had drugs before colonization. It is her experience that some of the kupunas are using methamphetamine too.

Co-researcher 6 had not heard of the term colonization before but stated that it made sense when she thought about all the changes that have occurred after Cook arrived in Hawaii. After reflecting on the word colonization, she expressed the feeling that colonization has been the cause of the trauma NHs experience. She expressed that if colonization had not occurred, NHs would not have the problems that they have today. Alcohol, methamphetamine, and marijuana would not be available to them. NHs would not have to pay mortgages and would not have the diseases they experience today. Co-researcher 6 feels that if Cook had not arrived that some other nation would have, and the situation might have been worse. One of her present-day concerns is the building of another telescope on sacred land. She does not want another telescope built on Mauna Kea and that the lack of concern for how NHs feel is offensive and shows a lack of respect.

Co-researcher 7’s experience of colonization and historical trauma is the loss of land, people, culture, and language. She expressed sadness that most NHs do not speak their language today and that the U.S. took the Hawaiian Islands and the land illegally by overthrowing the NH Monarchy. She feels that Hawaii should not be a state. She feels that Native Americans have experienced the same kind of losses. She expressed feeling anger that Westerners not only came and took everything but that NHs are discriminated against and are put down as "stupid." Before the land belonged to everyone, now many NHs cannot afford land. It is expensive to buy. She expressed that she does like development and does not want to see development happen in the area she lives in. Co-researcher 7 expressed that she does not want another telescope built on
Mauna Kea. She does not understand why they could not put the telescope in another location. Mauna Kea is sacred to NHs and is closest to the gods.

Co-researcher 7 feels that the health of NH people was better before colonization. Now NHs have chronic diseases such as diabetes and cancer, which did not exist before. She feels that the foods they eat today are of poorer quality. She also feels that there was no mental illness, but now NHs experience depression and suicide in the area. She feels that NHs have poorer health than other ethnic groups living in Hawaii. Before colonization NHs were strong, healthy, hardworking active people.

Co-researcher 7 expressed that NH people used a lot of alcohol, mostly beer before methamphetamine came to Hawaii. She feels that people like methamphetamine better because it is cheap and easy to acquire. NH people still drink a significant amount of beer in her area. She feels that NHs recognize that substances are not good for them, but both alcohol and methamphetamine numb painful feelings of all the losses. She acknowledged that she had used methamphetamine in the past, but personally does not use it anymore. Some of her family members continue to use both alcohol and methamphetamine. Co-researcher 7 feels that her family members do not realize the trouble alcohol and methamphetamine cause. She is concerned about seeing many of the school-age kids drinking and using methamphetamine and is concerned about the impact of these substances on them. She feels that the kids learn to drink when they see kupunas drinking. She feels that some of the kupunas do not think that drinking is a problem despite domestic violence problems. She feels that methamphetamine is becoming a bigger problem among NHs than alcohol.

Co-researcher 8’s experience of colonization and historical trauma is the loss of people, culture, and land after contact with Westerners. She expressed that many people struggle to own land. Rent and mortgages did not exist before colonization. She has been waiting to acquire
Hawaiian homeland property since she was young. She is still on the waiting list and feels that the people who manage it are corrupt. She expressed frustration about the properties in the area that NHs cannot afford. She feels angry that NHs were not allowed to speak their language after the missionaries came. She also expressed anger that the missionaries did not like NH culture or dance. She expressed feeling angry that NHs had to change their lifestyle, to speak English, to practice Western religion and wear Western clothes. Co-researcher also feels that Hawaii should not be state, and it should not be a part of the United States. Hawaii should be given back to NHs. She expressed that she does not know how to go about making this happen. Today, “Mauna Kea is another thing they are trying to take away.” She feels angry and expressed anger that NHs were never asked for permission to put any of the telescopes on Mauna Kea.

Co-researcher 8 expressed that a lot of NHs are considered obese and have chronic diseases, including diabetes and heart disease, because of dietary changes after colonization and that fast foods are cheap and easy to access. She expressed that it is too expensive to try to eat healthy all of the time. She is aware that other ethnic groups living in Hawaii have problems, too, but feels that NHs have more health problems than the other ethnic groups. She feels that before colonization NHs were healthy, active, and worked hard.

Co-researcher 8 feels that NHs drink a lot of alcohol, especially the area she lives in. She expressed that there is more alcohol, beer used in her area than any other place in Hawaii. Before methamphetamine came to Hawaii, alcohol was the most used substance in the area. She feels that people are starting to prefer methamphetamine over alcohol. She expressed that NHs like celebrations and serve beer. NHs have problems with drinking alcohol and using methamphetamine. Before hard liquor was introduced, NHs used Okolehao, the mildly narcotic drink made from ti plants. She did not know if NHs had Okolehao before colonization. She feels that NHs use alcohol and methamphetamine because there is not much else to do. She also
expressed that many people use alcohol and methamphetamine because they want to cover up feelings of losses. She feels that some of the kupunas drink alcohol and that they are the ones that show everyone else how to drink. She drinks alcohol, too, but does not become intoxicated. In the younger generation, she feels that alcohol and meth are significant problems.

Co-researcher 9’s experience of colonization and historical trauma is that after Captain Cook arrived, "Hawaii was no longer Hawaii;" NHs had to change how they lived. She feels that colonization also happened to AIs. Her experience of colonization is when other people come and "take away your land, then live on your land." Many non-Hawaiian people own the land and "don't want to share." She stated that NH lands were taken away, and with the land, they lost access to resources. Another significant event was the deaths of NH people who lacked immunity to the infectious diseases brought by Westerners. She feels that the NH culture started to fall apart after King Kamehameha died and when NH laws were eliminated.

Co-researcher 9 stated that NHs have the most health problems of all of the ethnic groups in Hawaii. NHs have chronic diseases that they did not experience before. It is her feeling that all Polynesians have the same health problems as NHs. They have more diabetes, heart disease, and cancer than other ethnic groups in Hawaii. They experience diabetes and kidney disease and need dialysis more than other ethnic groups in Hawaii. It is her understanding that NHs were healthy people before colonization. They did not have chronic diseases.

Co-researcher 9 expressed that almost all of the NHs she knows use alcohol. Her family experiences problems from alcohol use. She describes how she and other family members saw her grandfather drink, and so they would drink alcohol too. Her grandfather became sick from drinking alcohol and would hit her grandmother. Now she does not drink because she saw this happen in her family. She feels that drinking and domestic violence are issues that need to be addressed in the community and that domestic violence is a result of drinking alcohol. Another
significant concern she raised is methamphetamine use in the community. Co-researcher 9 feels methamphetamine is becoming a bigger problem than alcohol and feels that many people she knows prefer methamphetamine over alcohol. She expressed that she does not know what is going to help stop the use of alcohol and methamphetamine.

Co-researcher 9 had never heard of the term historical trauma but intuitively knew what it meant. She used Mauna Kea as an example. She expressed not understanding why another telescope has to be constructed on the mountain, which is sacred land to NHs. She feels that Hawaii does not belong to the United States, which is a reason not to put another telescope. She expressed that it shows disrespect to NH people. "Historical trauma is losing everything."

Co-researcher 10’s experiences of colonization and historical trauma after the arrival of Captain Cook is a sense of profound loss. She feels angry because the Hawaiian monarchy was overthrown by a group of American businessmen, sugar planters in 1893 after Queen had extended aloha to them. The Queen expected that the U.S. would be honorable and do the right thing and give Hawaii back to NHs because of aloha. She expressed that aloha is the experience of loving one another and feels that Hawaii should not be part of the United States and should remain independent. She feels guilty about being part Caucasian. To her, the word Caucasian is synonymous with Westerner, and her experience with Westerners is that they want to possess, take, and own everything. She feels that Westerners refuse to understand the NH concept of wealth, which is to give and share resources. She is sad and angry over the loss of the land, which was quickly taken away after ninety-five percent of the NH people died from infectious diseases. She feels sad and angry that the same people who brought the disease epidemics took the land too. She expressed grief, anger, and sadness over the loss of NH people and over the way they were able to live before colonization. She expressed that these sentiments have been passed down to the current generation of NHs. These sentiments fuel their anger. She feels anger
over how American missionaries changed NH's unrestricted sexual practices by restricting them. She expressed that these changes in lifestyle and sexual practices led to the cycle of violence that exists today among some NHs with an increase in rape, molestation, and child abuse, which did not exist before colonization.

Co-researcher 10 stated that she is aware that NHs overall health "is terrible" and that NHs are one of the most underserved populations in Hawaii. Her experience is that NHs suffer from chronic health co-morbidities, especially diabetes and high cholesterol. She describes that NHs suffer from multiple adverse childhood events (ACEs) and on screening have the worst scores of any other ethnic group in Hawaii. High scores on the ACEs screening tool indicate an increased likelihood of developing chronic diseases, mental illness, and early deaths. She expressed anger that this is part of the changes that have occurred since Captain Cook arrived. Her experience is that NHs were strong and healthy people before colonization. Good health is related to the land.

Co-researcher 10 stated that alcohol is sold at the cheapest in all islands in her area. She reports that NHs "love alcohol." She describes how people use it as a coping mechanism for their pain from the losses they have had and continue to have. She describes how alcohol is a significant problem because of its disinhibiting effects, which allows people to express anger, which results in violence. She describes how when people are in pain they drink more alcohol and alcohol allows people to be violent without the insight or judgment to control behavior which results in a lot of domestic violence. Co-researcher 10’s experience is that fatal car accidents, murders and suicides are often related to alcohol use among NHs. The use of alcohol in her own family is a cycle and she feels that "if you were talking to the kupuna in their 80s or 90s, they would tell you to drink. This most often results in a fight, and "old uncle is gonna punch somebody." She believes that these behaviors have been passed down intergenerationally
along with the introduction of alcohol; alcohol did not exist in Hawaii before colonization, and now it does. Co-researcher 10 describes how drinking alcohol is the way NHs deal with pain, cultural trauma, and historical trauma. It is her feeling that NHs do not know how to deal with the loss of land. She expressed her personal experience of being infused with the land, her family, and her island.

Co-researcher 10’s experience of growing up and learning about the history of colonization was that it was good to have been discovered and colonized because of the way historical accounts are presented. She expressed how she now sees the explorers as “terrible people” because they took everything from the NHs. They “took the land and killed the people all so they can have front row seats to the ocean.” In her view, colonization is "taking what does not belong to you and then doing what you want with it." She expressed anger about what is happening on Mauna Kea, which is a sacred place to NHs. She feels that Mauna Kea is being desecrated by putting up another telescope. She expressed that it is not about the 13 telescopes that are already there, but that NHs had said no to building telescopes before. She expressed wondering how much more NHs are going to take? NHs have to stand up and fight to protect Mauna Kea and that an agreement needs to be made with the NH people. She expressed knowing that they might lose the fight over Mauna Kea, but that the world will know NHs are right. She feels that thinking about colonization and historical trauma makes NH people angry and upset. She expressed that historical trauma is traumatizing, that she feels angry about the losses to the NH people and that historical trauma is something that is taught to others. For her and her family learning, NH culture is an ongoing process. Co-researcher 10 feels that both she and her family need to learn about their culture. They have to preserve what they have and to pass down the remaining cultural knowledge because, at some point, there will be no more kupuna to teach what was done before or after Captain Cook came. She expressed that it all started in 1778 and
feels that its "late in the game in 2019. Co-researcher 10 feels that the colonizers wanted the NH people dead because the people like the Dole plantation owners wanted NH lands. It is her feeling that when NHs can no longer pass down cultural knowledge, the traditions, practices, and the truth of what happened will be when NHs die. She also expressed that the NH people are strong, resilient, and have survived a lot. "We are still here." She stated that she first learned of the concept of historical trauma in the anger management classes she teaches. She is trying to help NHs figure out why they act out and why they are angry and expressed that anger is sadness and that people are killed because of anger and sadness.

Construction of an Individual Composite Description

All of the co-researchers communicated stories about their perceptions and experiences of colonization and historical trauma. All generously discussed historically traumatic events that occurred and expressed experiencing sadness and anger over the changes that happened to them, both past and present. All identified massive losses of NH people after contact due to infectious diseases. They shared experiences and feelings about the loss of lands, culture, and the ability to speak the NH language. Ultimately they described their perceptions and feelings about the loss of Hawaii, which was illegally taken in 1893 when Americans with business interests overthrew the NH monarchy, which was directly in conflict with NH cosmology.

The co-researchers shared that the Native peoples suffer from chronic diseases. Diabetes, heart disease, cancer and hypertension are discussed as the most prevalent chronic diseases experienced. The co-researchers expressed that poor health is due to an unhealthy diet. Today their diet includes a high percentage of high-fat foods and fast foods. Healthier choices are often too expensive or unavailable. Some expressed concerns that many NHs are unaware of how their current diet is impacting their health and described overindulgence with unhealthy foods. The NH co-researchers felt that before colonization NHs worked hard on the land and ocean, and
they were not inactive, but strong and healthy and without disease. They described that no one went hungry. Native cosmology is different, and land and food were shared with others. Today, people are required to pay mortgages, rent, and purchase food. Co-researcher 3 discussed how the NHs who live on Niihau still live the old way. If the individual develops a chronic disease such as diabetes, they have to leave Niihau and move to another island, which can provide essential medical care. Co-researcher 10 expressed that mental health is associated with sexual health, and because of restrictions in sexuality, there are mental health issues and domestic violence. Many felt that NH people suffer from depression and there has been an increase in suicides among NHs. Many of the co-researchers feel that no one is paying attention to NHs mental health. Many do not trust Western medicine and prefer traditional NH remedies.

The co-researchers described that Native peoples use a lot of alcohol and methamphetamine. Only one of the co-researchers' experience of alcohol was not a problem in his family. He felt that everyone handled alcohol well and reported enjoying drinking alcohol at family gatherings as long as it was managed well. Alcohol was found to be a big problem in many of the co-researchers' families and the community. Many of the co-researchers described how drinking alcohol was the norm with the kupuna in their families. Most of the co-researchers experienced that alcohol is a problem and that the kupuna drink alcohol and influence the younger generation to drink. Most of the co-researchers felt that drinking alcohol results in many cases of DUls, traffic fatalities, domestic violence, and jail time. One co-researcher described how the men in her family became intoxicated and hit their wives. All of the co-researchers felt that the more significant substance problem today is methamphetamine use. All of the co-researchers talk about how methamphetamine has become widespread and used either as much or more than alcohol now among NHs. One of the co-researchers described his personal experience with drinking alcohol, using cocaine and then methamphetamine. His experience is
that alcohol used to be the main problem among NHs, and now methamphetamine is a more significant problem. He described methamphetamine as more addictive, powerful, cheaper, and easy to acquire through Federal Express and the United States Postal Service. His experience is that NHs were once alcoholics are now drug addicts and who will continue to drink beer and smoke marijuana, but their drug of choice is methamphetamine. The consensus among the co-researchers is that often alcohol and methamphetamine are used to self-medicate painful feelings of losses.

Several of the co-researchers talked about how the kupuna teach the younger generation how to drink alcohol. They express sadness about how families have been broken by alcohol use and difficulties in managing the use of alcohol. The authorities have to intervene when behavior becomes hard to manage. One co-researcher expressed concerns that if marijuana were to become legalized, they would never be able to stop or gain control over the use of alcohol and other drugs. One co-researcher recognized that alcohol and the regulation of alcohol by the colonizers before Hawaii became a state was used as a means to help overthrow the NH monarchy. Concerns were expressed by the lack of research being conducted on the effects of alcohol on NHs. Several of the co-researches felt that it is crucial because NHs are self-medicating from all of the losses and experiences of discrimination. Several co-researchers expressed that NHs in their area drink the most beer in the state of Hawaii because it is cheaper than anywhere else in Hawaii. One of the co-researchers knew that Okolehao existed after Captain Cook had arrived. She felt that the introduction of Okolehao started NHs problems with alcohol. One co-researcher expressed that NH men, in particular, experience discrimination and oppression. The impacts of discrimination and oppression on mood causes depression and anger. Many co-researchers feel that discrimination and losses are reasons that many drink alcohol and use methamphetamine to mask feelings.
The student researcher felt grateful that the co-researchers would take the time to welcome her back into their community and to share their stories generously. Her experience was very similar to those of theirs. Even though some of them had not heard the words colonization or historical trauma, they all immediately knew and understood what it meant to have Westerners take over their islands and what historical trauma meant. Many expressed that it spoke for itself. Those co-researchers who did not know what the term colonization meant knew it was a Western concept and they wanted to learn more about it. The student researcher was aware that they already knew the meaning; they needed to connect the concept with the arrival of Westerners to their islands and with the historically traumatic events that their ancestors had to endure starting 241 years ago and the proximal events that they continue to experience today. The most recent event is the attempt to build a 14th telescope on Mauna Kea, and current losses that continue today. As one of the co-researchers expressed it is not only that it is a sacred mountain where the ancestors are buried, and where the gods lived, but the building of another telescope will continue to affect future generations of NHs. All of the co-researchers expressed anger, sadness, and grief over the events on Mauna Kea and willingness to fight for its preservation. They are tired of being disregarded and of having everything taken away from without their consent. Today many NHs are going to law school to learn how to legally stop these kinds of intrusions in their homelands. It is not a matter of not being intelligent. It is a matter of having a different worldview on how and why things should matter and how things should be done as one of the co-researchers stated.

The Final Steps of Analysis: Imaginative Variation and the Synthesis of Meanings

The final step of the analysis of the Stevick-Colaizzi-Keen method is the synthesis of textural meanings and structures using imaginative variation (Moustakas, 1994). The structures underlying the co-researchers’ textural perceptions of the phenomenon were brought to light in
each of their stories. The structures were clearly and unambiguously revealed as universal invariant and unchanging to all co-researchers. The textual perceptions of the phenomenon, as expressed through the thoughts and feelings of the co-researchers and the structural meanings that underlie the phenomenon, are expressed through the universal structures. Imaginative variation was used by the student researcher to intuitively synthesize the composite individual-textural descriptions into the following universal composite textural-structural in order to answer the research question. Before the synthesis of meanings, it is essential to discuss the concepts of noeses, noesis, and noema in order to understand how meaning is generated. These concepts provide a framework from which to understand how the co-researchers perceive and experience or the phenomenon under study and which are essential to transcendental phenomenology studies.

**Intentionality: Noeses, noesis, and noema.** Intentionality is the act of directing the mind towards thinking about an object, either real or imaginary, actual or nonexistent. Intentional experiences are comprised of both a noetic side and a material side. Husserl (1931) introduced the concepts of noeses, noesis, and noema. The concept of noeses comprises the mind and the spirit, which brings into the consciousness an awareness of an object. Thus, in and through the noeses, an object will emerge into consciousness. The noetic characteristics of an object are psychical or thinking, reflecting, feeling, remembering, and judging in contrast to a material side. Noesis is the intentional act of directing the conscious towards seeing, perceiving, feeling, thinking, remembering, and judging an object. Concealed meanings are embedded in an object as it emerges into consciousness, and these meanings must be recognized and revealed (Moustakas, 1994).

A noema or noemata (plural) has several interpretations. However, among philosophers, there has not been a consensus on precisely what noema/noemata are. There are three primary
schools of thought on understanding noema in phenomenology studies on consciousness. One view is a transcendental interpretation of noema. In this view, a noema is considered to be the intentional object of an act of consciousness. The noema is the object. For example, an object such as a tree is as it appears, merely a tree and even a fictional tree also exists. Both of these interpretations have different modes of existence, one real and one fictional. An alternative view of noema consists of interpreting noemata (plural). The interpretation is a function of understanding noema/noemata within a part-whole schema. In this view, the noema represents the perceptual experiences of an object. In other words, a tree can be perceived from different vantage points and different perspectives. What is perceived from each vantage point is a noema or from many vantage points and many perspectives or noemata. In this case, the tree is understood as a collection or a system of noemata that is associated with the act of viewing the tree from different vantage points where the noema are not separate. A tree is an object that is perceived and judged. Another interpretation of noema is that it is the actual object of perception or judgment, which is in keeping with Husserl's (1931) interpretation, which is the interpretation selected for this study. The noema ascribes meaning to an object which is being perceived through seeing, touching, feeling, thinking, or judging. Experiences that hold essential meanings are created through these processes, which can be revealed by intentionally directing them towards an object through conscious thought processes.

According to Husserl (1931), the noema of an object corresponds to all aspects of the noesis. Therefore, when a noesis exists, it corresponds to a noema. He describes noema as the perceptual meanings of a phenomenon and how a phenomenon is experienced, perceived, and remembered. Ihde (1977) offered a more clarifying distinction to Husserl's (1931) interpretation of noema. He described the noema not only as that which is being experienced but also as the what of the experience. He described the what as the object in question. By using this
interpretation, for this study, the object is the phenomenon of colonization, historical trauma, and links to alcohol use among NHs. The noeses (textural perceptions) are how, the what or the noema or the phenomenon under study is perceived and experienced by all co-researchers. The noesis, textural perceptions were expressed through the thoughts and feelings of the co-researchers. These were described in detail in the discussion of the core themes and the individual and composite textural descriptions. Imaginative variation enabled the student researcher to derive structural core themes from the individual and composite textural descriptions acquired through phenomenological reduction. The universal structures are discussed in specific detail below and are interpreted through the universal structures of time, space, bodily concerns, materiality, causality, self in relation, and relation to others (Moustakas, 1994).

**Construction of Individual Structural Descriptions**

Individual structural descriptions were constructed from the outcomes of the process of imaginative variation. The exemplars that were constructed demonstrated invariant constituents and unchanging horizons. The universal structures were identified and used to construct individual structural descriptions of the co-researchers including universal structure of a) time, b) universal structure of space, c) universal structure of bodily concerns, d) universal structure of materiality, e) universal structure of causality, f) universal structure of self-in-relation, and g) universal structure of relation-to-others. The composite structural description was constructed from the individual structural descriptions, which were universal to all of the co-researchers. The meanings and essences of the textures and structures are discussed below in the synthesis of meanings into the composite textural, structural description.

**Imaginative variation and the synthesis of meanings.**
Composite Textural and Structural Description. The feelings recounted by the co-researchers as they reflected on the impact of colonization were of loss, sadness and anger and unresolved grief over the losses that have occurred over the last 240 (time) years ago since Captain Cook arrived for provisions (materiality) and then the arrival other Westerners (relation to others) as they settled and colonized Hawaii (space). The loss of ninety-five percent of NH people to infectious diseases (bodily concerns) was catastrophic (causality). Contact with Westerners (relation to others) beginning in 1778 (time) began a cascade of events (causality) that nearly resulted in the loss and near extinction of the NH people (self in relation). Before contact with Westerners (relation to others), NHs experienced little disease or illness (bodily concerns) and had a strong economy (materiality). With the loss of people came the loss of leaders along with cultural knowledge (self-in-relation). The influence (causality) of Protestant missionaries (relation to others) led to the loss of language and religion. Western influence on NH leaders (relation to others) led to the loss of lands and resources (materiality).

NH lands used to provide abundant resources (materiality) and allowed them to live well without diseases and with good health (bodily concerns). Today, many struggle with chronic diseases (bodily concerns) resources (materiality) including land ownership, the ability to pay mortgages and rent on lands (relation to others) that used to belong to their families (relation to self). The foods (materiality) that were once abundant are less available, and most of the affordable foods are often of more inferior quality (bodily concerns). Without the land (space) to work (self in relation) to provide resources (materiality), there is a lack of physical activity (bodily concerns). This, coupled with the poor quality of food (materiality), has led to chronic diseases such as diabetes, heart disease, hypertension, cancer, and arthritis (bodily concerns). For many NHs the relationship (self in relation) between land (space), life, cultural beliefs and food (materiality) continues to remain deeply entrenched within the current struggles (relation...
to others) that NHs have over land (space) and health (bodily concerns) that are a result of colonization (causality).

Alcohol (materiality) has remained a problem (bodily concerns) since it was introduced in 1780 (time). Beer is considered a norm today and is used routinely used at family and community celebrations (relation to others). Alcohol is a problem that has gone unrecognized in the NH community (bodily concerns). Domestic violence, DUIs, problems with the law, and deaths related to alcohol are common problems in the community (self in relation, relation to others). Beer is available and is cheaper (materiality) in this area (space) of Hawaii.

Some kupuna overindulge (bodily concerns) and drink alcohol and teach the younger generation how to drink too (relation to others). Alcohol is used to celebrate but also misused (self-in-relation) to cover up feelings of sadness, anger, discrimination, and grief related to lack of access to and loss of land (space) and resources (materiality), which could improve the quality of life (self-in-relation). Some who have witnessed domestic violence related to alcohol do not drink and try to teach their kids (relation to others) not to drink (bodily concerns). Many do not know whether alcohol existed prior (time) to the arrival of Westerners (relation to others). Alcohol did not exist before (time) colonization. Alcohol (materiality) was introduced by Westerners (relation to others) and continues to be a problem today (bodily concerns).

Methamphetamine (materiality) has become a problem (bodily concerns) that is equal to or greater than alcohol (bodily concerns). It is cheap (materiality) quickly sent by mail (space) and is now the preferred (self in relation) drug over alcohol. It is considered to be more effective in getting high or covering up feelings (self in relation).

The historical (time) accounts are that alcohol (materiality) did not exist in Hawaii before Captain Cook's arrival in 1778 (relation to others). Awa (material) the mildly narcotic drink was the only substance present in Hawaii, which was used in spiritual practices (self in
relation) and as medicine (bodily concerns). Alcohol (materiality) first appeared in Hawaii in 1780 (time) as crude beer (materiality). Okolehao was made to prevent scurvy among the sailors (bodily concerns). Twenty years later (time), NHs were taught (relation to others) how to distill the crude beer into liquor (materiality). King Kamehameha I died in 1818 (time), but he had already acknowledged that alcohol (materiality) had a harmful effect on NHs (bodily concerns), including himself (self-in-relation). The missionaries had arrived in 1820 (relation to others), and alcohol (materiality) had already become a high stakes commodity in trade (materiality). The missionaries were concerned over their own self-interests (self in relation) and interference with commerce and trade (materiality). They were worried (self-in-relation) that the monarchy would not be able to manage alcohol (materiality) and public disorder (space) caused by White foreigners (self-in-relation), not only NHs (relation to others). The laws that were established to control alcohol among NHs (relation to others) was a part of an approach to colonizing Indigenous populations (self-in-relation). The laws that the colonizers applied to NHs were the same laws that were applied to AIs and ANs and for the same reasons (relation to others) and that NHs were not capable of governing if alcohol was involved (relation to others). A significant difference between the laws in Hawaii enacted to control alcohol was that the missionaries influenced the NH monarchy to use the same laws regulating alcohol as the U.S. government used with AIs and ANs (bodily concerns, self in relation, relation to others). The colonizers (self in relation) considered NHs to be more vulnerable (Bodily concerns) to alcohol and inferior to Whites (relation to others). As with AIs and ANs, the introduction and regulation (relation to others) of alcohol (materiality) among NHs as a means of establishing and maintaining control continued to erode NH culture and power (relation to others). The introduction and regulation of alcohol with NHs (causality) played a role in the breakdown of NH culture (relation to others), leading to the illegal overthrow of the
NH monarchy (self-in-relation) and the founding of a new American colony (materiality).

Alcohol use among NHs was no longer a concern (bodily concerns) after the NH monarchy was overthrown (relation to others). Alcohol remains a largely unacknowledged problem among certain NH communities today (bodily concerns). Today methamphetamine has become a problem equal to or greater than alcohol (bodily concerns).

Chapter 4: Summary

Chapter 4 describes the findings of this research study. Moustakas' (1994) modification of the Stevick-Colaizzi-Keen method of phenomenological data reduction required that the student researcher use imaginative variation to construct individual textural and structural descriptions from each of the ten co-researcher's interviews, including her self-interview. The analysis included the synthesis of meanings incorporating the concepts of intentionality, noesis, and noema. The composite textural-structural description was completed through the process of imaginative variation by synthesizing and integrating the individual textural-structural descriptions into a universal or composite description of the co-researchers’ experiences represented as a whole (Moustakas, 1994, p. 123).
Chapter 5: Discussion, Implications and Recommendations

Chapter 5 presents a discussion of the findings and the relationship of the findings supported in the existing knowledge base and the Literature Review, Chapter Two. The new findings generated by this study will add to the existing knowledge base on the phenomenon of colonization, historical trauma, and links to alcohol use among NHs in rural Hawaii in the 21st century. The limitations of the study will be presented. Additionally, the implications and recommendations for future research and policy development will be discussed.

Discussion

The history of NHs has not been unlike that of AIs and ANs. This was represented in the stories of the co-researchers and well documented in NH historical accounts (Daws, 1974; Stannard, 1989; 1992). NHs like AIs and ANs have all suffered colonization and social, political, and cultural subjugation in their ancestral homelands (Pokhrel & Herzog, 2014). As with AIs and ANs, contact with Westerners and the rapid colonization and settlement in Hawaii after 1778 devastated the NH people through catastrophic disease epidemics (Daws, 1974; Stannard, 1989; 1992). Prior to contact with Westerners, NHs experienced little disease or illness (McMullin, 2005; Wong & Kataoka-Yahiro, 2016). Today, per the accounts of the co-researchers, their current proximal struggles (see figure 1) over land, resources, and health, which began historically or distally (see figure 1) continues today.
The consequence of the losses of NHs as with AIs and ANs was the loss of leaders, cultural knowledge, traditions, land, identity, and traditional ways of subsisting. As with AIs and ANs the loss of land, culture, language and dispossession are primary causes of the many social and health problems NH people have today. These losses and dispossession have been posited to be the primary cause of the many social and health problems Indigenous people have today. As two of the co-researchers discussed, genocide through the loss of land, people, language and culture, has made a lasting impact on the NH peoples’ well-being. Disparities in NHs socioeconomic and health status as with AIs and ANs has arisen from the inequities in wealth and power that resulted from these losses. NHs were left with limited resources and poor access to quality healthcare, similar to AIs and ANs. Furthermore, past and current U.S policies
continue to foster socioeconomic disadvantages and resource alienation among NHs, AIs, and ANs. We see that resource alienation contributes to inadequate housing, poor education, low income, unemployment, substance use, violence, overcrowding, poor hygiene, and reduced personal, familial, and collective well-being (Cunningham and Stanley, 2003; Durie, 2004).

Other U.S. policies that forced assimilation, segregation, and cultural pluralism led to an oppressive dynamic that continues to disempower Indigenous communities and continues to promote the creation of stereotypes and reinforce racism (Gone, 2014). The U.S. policies that prohibited AI and AN cultural practices and language also sequestered AI children in boarding schools away from their families (Charbonneau-Dahlen et al., 2016; Gone, 2013) is similar to what NHs have experienced by the forbidding of traditional practices and speaking the Hawaiian language with the explicit purpose of assimilating them.

**The Introduction of Alcohol to NHs**

The introduction to alcohol to NHs in 1780, along with countless other atrocities, helped to fuel the near genocide of the NH people. This approach to colonization is similar to AIs and ANs. This author argues that the introduction of alcohol and the spread of infectious diseases as with AIs and ANs served as two major forces that allowed colonial expansion in Hawaii. History has revealed that the dominant colonizing population deliberately spread smallpox in blankets to some AI tribes on the east coast of the U.S. mainland with the explicit purpose of exterminating them to acquire their lands and to expand colonization (Dahlen, 2010; d’Errico, 2010). The colonizers introduced rum to AIs on the eastern seaboard and then expanded alcohol into the west, into Indian country with the explicit purpose of weakening AIs with alcohol's intoxicating effects (Franklin, n.d.) to acquire Indigenous lands. The losses due to disease epidemics that were incurred secondary to foreign encroachment in Hawaii during the 18th and 19th centuries and the introduction and regulation of alcohol played a significant role in the breakdown of NH
culture which led to the eventual overthrow of the Hawaiian monarchy and the establishment of a new American colony in Hawaii (Brown, 2003).

**Links Established between Colonization, Historical Trauma and Health Disparities**

Research shows that Indigenous groups experience significantly higher rates of physical and mental health disparities, alcohol, and other substance use and higher rates of suicide than other populations in the United States. Furthermore, Indigenous people live shorter and more challenging lives due to much higher rates of exposure to proximal traumatic events (Armenta, Whitbeck & Habecker, 2016; Balsam, Huang Fieland, Simoni, & Walters, 2004; Beals et al., 2013; Dickerson et al., 2018; Ehlers Gizer, Gilder & Yehuda, 2012; Herne et al., 2014; Kaholokula et al., 2006; Manson et al., 2005; Martell et al. 2016; Myhra, 2011; Myhra & Wieling, 2014; Pokhrel & Herzog, 2014; Sotero, 2006; Substance Abuse and Mental Health Services Administration (SAMHSA), 2015; Tucker, Wingate, & O'Keefe, 2016; Walls & Whitbeck, 2012; Weaver & Brave Heart, 1999; Whitbeck, Adams, et al., 2004; Whitbeck, Chen et al., 2004). These health disparities are postulated to stem from exposure to colonization and historical trauma. These are public health concerns, which creates a critical need to reduce the gap in NH/Al/AN health disparities. Many AI and AN groups have not yet been studied in their specific sociocultural contexts. Other NH groups need to be studied in their specific contexts as assimilation has occurred to varying degrees on different islands and in different areas of the islands. Both quantitative and qualitative studies are needed. From a qualitative perspective, it is important to explore their lived experiences and perceptions of colonization, historical trauma, and the use of alcohol and other substances in order to contribute to the development of culturally appropriate interventions for health promotion.

**The Relevance of Historical Narratives**
History or distal events (see Figure 1) provides a narrative within which current or proximal events (see figure 1) and social issues can be interpreted. It is this author’s position that by integrating cultural knowledge, narratives and the histories of Indigenous groups into social science research on health we can improve the cultural relevance of research findings in these populations and enhance interventions. NHs, as with AI and AN histories include colonization, trauma, and the introduction of alcohol and now other substances which are detrimental to health. The question becomes to what degree does colonization, and historical trauma impact these populations and how would Indigenous research help continue to support and promote resilience.

A narrative on colonization and historical trauma using story theory as a guide can offer a framework for gathering Indigenous stories. Indigenous perspectives help analyze how colonization and historical trauma and links to the use of alcohol and other substances have been transmitted and are connected to the present-day contexts by using indigenous storytelling methodology. Storytelling is in keeping with the Indigenous ontology of circularity. Also, a narrative helps to contribute to the development of culturally congruent interventions for health prevention and promotion.

**Theories and Frameworks**

Brave Heart's (2011) theory of historical trauma and Sotero's (2006) comprehensive diagram and conceptual framework of the impact of colonization and historical trauma on Indigenous groups provided the overarching principles guiding this research. Kirmayer & Gone's (2014) socio-psychological explanatory framework illustrated how experiences of trauma could be transmitted across generations through oral traditions and storytelling. The experiences of trauma and the stress response results in changes to an individual's mental and psychological well-being, self-efficacy, self-esteem, family functioning, community integrity, and cultural
identity. Sotero's (2006) Historical Trauma Conceptual model provides a framework and illustrates the multi-level processes of intergeneration transmission of trauma experiences that include the epigenetic transmission of the stress response, which was not addressed in this study.

The historical trauma concept first postulated by Brave Heart (2011) for AIs and represented by Sotero's (2006) Historical Trauma Conceptual Model is reflected in the findings of this study. Additionally, the Historical Trauma Socio-Psychological Explanatory framework (Kirmayer & Gone, 2014) provided a platform and a lens from which to explore the co-researchers’ experiences of colonization, historical trauma and links to alcohol use and other substance use. Storytelling methodology informed by Story Theory (Smith & Lehr, 2014) allowed the student researcher and co-researchers to explore their perceptions of the cumulative intergenerational impact of colonization and historical trauma and to links not only to past or distal collective experiences but to current or proximal collective experiences of psychological stressors. Distal and proximal stressors which have had a cumulative effect on the physical and mental health of the Indigenous populations. The student researcher and ten co-researchers demonstrated through storytelling that the traumatic impact of colonization had been passed intergenerationally by the parent and grandparent generations, a secondary mechanism of transmitting psychological stress. Moustakas (1994) hypothesized that all perceptions and experiences have essential underlying structures. Accordingly, the underlying structures of colonization and historical trauma and intergenerational transmission are the same among the NH co-researchers and very similar to the experiences of the AIs and ANs.

**Historical Trauma Theory (Brave Heart, 2011)**

Historical trauma is defined as the cumulative, emotional, and psychological distress that is transmitted across generations, including the lifespan and stems from massive group trauma experiences (Brave Heart, 1998; 2003; Brave Heart et al., 2011). Historical trauma theory for AIs
and ANs has provided a platform from which trauma can be framed throughout the lifespan from a collective, group historical context. The theory in part was meant to decrease the stigma and isolation that results from the sequelae of historical trauma and to empower the survivors. Historical loss has been used as a measure of historical trauma in Indigenous research (Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004). Historical loss was one of the primary themes the co-researchers presented in their stories.

**Historical Trauma response (HTR).** The historical trauma response (HTR) conceptualized by Brave Heart (1995) as a constellation of features or conditions that are associated with reactions of affiliated groups to massive group trauma experiences. The symptoms of HTR include depression, anxiety, self-destructive behaviors, suicidal thoughts and actions, low self-esteem, anger, and difficulty recognizing and expressing emotions. Many of these symptoms were expressed by the co-researchers. Also, the use of alcohol is considered a means of avoiding these painful feelings through self-medication (Brave Heart et al. 2011). The use of alcohol and methamphetamines as a means of avoiding painful feelings of losses was also expressed in the co-researchers' stories.

**Historical unresolved grief (HUG).** Historical unresolved grief is a feature of HTR. This feature has been defined as the intensely unsettled sadness which results from devastating cumulative losses; losses have been compounded by the interruption and the forbidding of traditional ceremonies and burial practices and language (Brave Heart et al. 2011). Whitbeck Adams et al. (2004) found that thinking about historical trauma is associated with psychological and emotional distress, especially depression and anger. All co-researchers expressed sadness and many feeling angry over significant losses they, their families, and communities have experienced after the arrival of Westerners.

**Historical Trauma Conceptual Model (Sotero, 2006)**
Sotero's (2006) Historical Trauma Conceptual model (figure 1) illustrates that historical trauma is a disease of time, both distally and proximally which comes from the perspective that the poor health status of Indigenous populations is the result of the accumulation of social distress whereby both physical and psychiatric disorders are transmitted to subsequent generations. Maladaptive behaviors develop as a result of ongoing social problems such as substance abuse, physical abuse, and suicide. These behaviors traumatize the next generation and become learned behaviors that are passed intergenerationally and continue to perpetuate the intergenerational cycle of trauma. Successive generations of Indigenous peoples can experience vicarious trauma exposure through collective memory and through storytelling or oral traditions. The traumatic events and behaviors become embedded in the collective social memories of the group, and succeeding generations are taught to share in the ancestral traumas and, in some cases, develop strong feelings of unresolved grief. Strong feelings that are associated with historical trauma are related to poorer mental health outcomes, which result in a greater likelihood of developing maladaptive behaviors such as alcohol and other drug use. Historical trauma is a stressor that increases the likelihood of these health risk behaviors. Pokhrel and Herzog's study in 2014 was the only study found in the literature that specifically studied the impact of historical trauma on NH college students and the use of substances through the lens of historical trauma theory. This conceptual model provides a schematic from which to view the impact of colonization and historical trauma expressed in the co-researchers’ stories and the mechanism of intergenerational transmission of the secondary trauma they expressed experiencing.

**A Socio-Psychological Explanatory Framework (Kirmayer & Gone, 2014)**

A historical trauma socio-psychological explanatory framework has highlighted the potential and relevance of using a traditional approach informed by Story theory and using
storytelling methodology as a means of exploring the experiences and perceptions of the cumulative, and intergenerational impact of historical trauma (Gone, 2013). Storytelling methodology can facilitate linking past collective experiences of others to those in the present time (Brave Heart, 2003; Smith & Liehr, 2014). Parental communication can occur through Indigenous storytelling. Oral traditions can be a mechanism of secondary transmission of psychological trauma (Gone, 2013; Palacios & Portillo, 2009). Researchers have demonstrated interest in historical trauma in many disciplines. However, the challenges have been on how to make sense of the literature and how to integrate the literature with Historical Trauma theory in order to advance scientific inquiry (Kirmayer & Gone, 2014). This study sought to accomplish this task.

**Historical Trauma and PTSD**

**Historical trauma features experienced by the co-researchers.** As discussed in Chapter 1, historical trauma has been proposed to be an expanded and more complex manifestation of PTSD. Historical trauma affects collective groups as opposed to individuals. Historical trauma has been defined as the cumulative emotional and psychological distress that is transmitted across generations, and that arises from group trauma experiences (Brave Heart, 1998; 2003; Brave Heart et al., 2011). All of the co-researchers in the study discussed the psychological and emotional impact of colonization they have experienced. Brave Heart et al. (2011) conceptualized the constellation of features of HTR that collectively affects individuals within a group and who have experienced immense group trauma. The features of HTR comprise many of the symptoms of PTSD. This author would also argue that intrusive thoughts and re-experiencing the secondary trauma should also be features of HTR. The features of HTR that are important to reiterate include anger, depression, anxiety, self-destructive behaviors, low self-esteem, and difficulty recognizing and expressing emotions. The co-researchers endorsed
experiencing many of these symptoms and features either as individuals or seeing the features experienced by family and community members. These features are highlighted and expressed in their verbatim interviews represented by the five broad themes discussed in Chapter Four. Of the five themes, unresolved grief was the most universal in the co-researchers’ stories.

The co-researchers endorsed experiencing that many in their community have experienced unresolved grief, a feature of HTR, defined as the profoundly unsettled bereavement that results from devastating cumulative losses. Losses that are compounded by the interruption and prohibition of traditional cultural practices and burial practices (Brave Heart et al. 2011). As with AIs and ANs, several of the co-researchers felt that the use of alcohol, and now methamphetamine, are being used by NHs for self-medication to avoid painful feelings from all of the catastrophic losses they have experienced. Whitbeck, Adams et al. (2004) found that thinking about historical trauma is associated with psychological and emotional distress, especially depression and anger which were features that were also expressed by the co-researchers in their stories.

To reiterate, PTSD is a disorder characterized by severe acute and long-term effects of exposure to traumatic stressors, which can occur through secondary transmission. So, it can be argued that chronic and cumulative trauma can be transmitted through secondary transmission and through parental communication or storytelling. Secondary transmission can create emotional scars that have the potential to affect life-long patterns of behaviors, interpersonal relationships, role performance, and the ability to develop skills (Gone, 2009; 2013; 2014). The co-researchers reported that either they themselves, their family or community members have experienced or continue to experience features of PTSD and alcohol and or methamphetamine use. The features of PTSD include: a) experiencing direct or indirect exposure to trauma, b) intrusive thoughts and re-experiencing the trauma, c) avoidance, d) negative mood, e)
hyperarousal and reactivity, f) symptoms lasting for one month or longer in duration; g) cause significant functional impairment; and h) is not attributable to the physiological effects of a medication, substance, or another medical condition (American Psychiatric Association, 2013, pp. 271-274). The features of PTSD highlighted in the co-researcher's stories include re-experiencing indirect exposure to the traumatic stress that their ancestors endured through stories from the kupuna and experiencing intrusive thoughts about the loss of people, land, and cultural traditions and experiencing institutionalized racism. They also expressed experiencing negative cognition, and mood symptoms which they described as sadness and anger over the losses of people, land, language, and culture. One example of current struggle and potential loss expressed by the NH co-researchers is the further desecration to Mauna Kea and the building of another unwanted telescope. The co-researchers also expressed experiencing hyperarousal and reactivity, including the experience of discrimination, which serves as reminders of losses they have incurred when they think or hear what is happening on Mauna Kea.

The co-researchers’ experiences support that the secondary transmission of intergenerational transmission of trauma through stories is a phenomenon. Secondary trauma exposure can be assessed and diagnosed in mental health settings and also measured in research. It was an important change to the DSM-5’s criteria by including secondary trauma transmission of a traumatic event that has occurred to close friends, family and community members, and the repeated exposure to details of the traumatic events. This study demonstrated that the NH co-researchers experience many of the features of HTR, including unresolved grief from being exposed to the learning of past events that affected the NH people and to repeated exposure to the details of those events. Additionally, many individuals experience symptoms of PTSD on a regular basis, and many in the community reportedly use alcohol and methamphetamine as a means of coping.
**The Findings Supported by the Existing Data Base and Literature Review**

**Findings Supported by the Existing Database**

The co-researchers’ experiences are reflective of previous findings in the existing knowledge database, which has been studied in other contexts, including other AN tribes and groups. Populations not addressed in this study who have also experienced traumatic events include, 1) former slaves, 2) veterans of armed conflicts, 3) POWs, 4) survivors of terrorist attacks, 5) WW II Holocaust survivors and 6) other ethnic groups and 7) healthcare providers who work with victims of trauma. This implies that historical trauma and intergenerational transmission is a universal concept among different populations, groups, and contexts and that the findings of this research study are likely transferable to other studies of groups who have experienced traumatic events.

**Findings Supported by the Literature Review**

The findings in this study are supported by five broad themes that were identified in Chapter 2, the Literature Review with other Indigenous populations. The themes are as follows: 1) unresolved grief over losses, 2) excellent health before to the worst health after colonization, 3) alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination, 4) the kupuna teach the younger NHs to drink alcohol and 5) understanding the impact of colonization and historical trauma. The findings are discussed below.

**Unresolved grief over losses.** One of the themes identified in the literature review was unresolved grief over losses among AIs/ANs and NHs. The NH co-researchers experiences are consistent with several studies that discovered evidence of an AI/AN/NH holocaust that occurred through epidemics of disease, annihilation through military aggression, and the implementation of colonist expansion policies that forced social changes that contributed to the loss of traditional culture, language and identity (Brave Heart, 1995; Brave Heart, 1998; Brave Heart, Chase,
Exploring a Shared History of Colonization, Historical Trauma

Elkins & Altschul, 2011; Brave Heart & DeBruyn, 1998; Sotero, 2006; Stannard, 1989; 1992; Struthers & Lowe, 2003; Weaver & Brave Heart, 1999). Land and resources that had value to the U.S. government were taken by force, and Indigenous peoples were marginalized and resettled in restricted areas elsewhere. As part of the removal process, many Indigenous people died from disease, starvation, and fatigue (Brave Heart, 1995; Brave Heart, 2003; Weaver & Brave Heart, 1999; Wimbish-Cirillo, 2016).

Excellent health to the worst health after colonization. The theme of going from excellent health to the worst health after colonization was supported in the literature review. The co-researchers' stories are consistent with several studies. First, contact with Westerners led to a rapid and precipitous decline in the NH population similar to that experienced by AIs and ANs (Charbonneau-Dahlen, 2010; Lowe, & Morris, 2016; Denham, 2008; Brave Heart, 1998; 1999; 2003; 2011; Brave Heart-Jordan, 1995; Stannard, 1989; 1992). Epidemics of bubonic plague, smallpox, whooping cough, venereal disease, pneumonia, mumps, and other infectious diseases were introduced to Indigenous peoples. Stannard (1989) estimated that the NH population in 1778 was between 800,000 to 1,000,000, and by 1893, the time of the overthrow of the NH monarchy, the population had been reduced to approximately 40,000, a 95% reduction in the population.

Today Indigenous communities experience a disproportionately higher rate of chronic diseases, psychiatric disorders, and substance use disorders than other ethnic groups living in Hawaii. An estimated 75% of AI adults are overweight or obese (CDC, 2017). AIs and NHs are two to three times more likely to have diabetes than Whites (Grandinetti et al., 2007). The prevalence of heart disease is 20% higher in AIs compared to other ethnic groups in the U.S and 68% higher in NHs compared to other ethnic groups in Hawaii. Additionally, Indigenous people
have been posited to live more challenging and shorter lives and die approximately a decade earlier than other ethnic groups (Dickerson, et al., 2018).

Researchers have identified historical trauma as a precipitating cause that influences ethnic health disparities (Dickerson, et al., 2018; Grandinetti et al., 2007; Sotero, 2006; Walters & Simoni, 2002). Williams, Neighbors, and Jackson (2003) identified historical trauma affecting Indigenous groups as a macro stressor that affects large scale systems that impacts the physical and mental health of the affected Indigenous groups. Walters and Simoni (2002) described historical trauma from an Indigenous fourth world context where Indigenous groups exist in a Nation where the dominant, colonizing majority hold constitutional power and privilege and the cumulative effects of discrimination and injustice impacts the health outcomes of Indigenous peoples (Walters & Simoni, 2002).

**Alcohol and methamphetamine addiction are a problem.** The theme of alcohol and methamphetamine addiction is a problem that is supported in the literature review. The co-researchers’ experiences are consistent with several studies. AI/AN/NHs experience significantly higher rates of alcohol and other drug use, suicide rates, and traumatic exposure (Beals et al. 2013; Dickerson et al., 2018, Pokhrel & Herzog, 2014). NHs have been overlooked in research as a separate group from other ethnic groups in Hawaii; however, NHs are at a significantly higher risk for poor health behaviors and outcomes, including substance use compared to other ethnic groups in Hawaii (Pokhrel & Herzog, 2014). NHs of all age groups show a higher prevalence of tobacco and other substances use. Pokhrel and Herzog's (2014) study was the first attempt to study historical trauma among NHs empirically in the setting of alcohol and other substance use using existing historical trauma measures. Their findings were that perceived discrimination mediated the effects of historical trauma on substance use or were a predictor of substance use, which highlights the importance of studying perceived ethnic
discrimination. They also noted that historical trauma might have had a protective effect on substance use, but stressed the need for additional research on historical trauma, substance use, and perceived discrimination. Two of the quantitative studies established that historical loss thinking is prevalent among AIs and also associated with the use of alcohol (Whitbeck, Adams, et al., 2004; Whitbeck, Chen et al., 2004) and perceived discrimination was positively associated with alcohol misuse in AI women. Another study established that AI participants with higher historical loss thinking had a higher likelihood of using alcohol within the past 30 days (Wiechelt et al., 2012). Another study established that traumatic events that involved both parents and children were linked to the onset of alcohol misuse (Myhra & Wieling, 2014). Another study demonstrated that drinking and other substance use was significantly associated with intergenerational depression symptoms, the effects of relocation programs, and lower rates of supportive parenting (Walls & Whitbeck, 2012). Myhra’s (2011) study on the intergenerational transmission of historical trauma among AIs and ANs established that substance abuse was strongly associated with the negative impact of historical trauma and experiences of microaggressions and intrafamilial traumas.

The kupuna teach the younger NHs to drink alcohol. The theme that the kupuna teach the younger NHs to drink alcohol is supported in the literature. However, more studies are needed to explore the intergenerational transmission of alcohol and other substance use from the kupuna to younger generations. The co-researchers' experiences are consistent with several studies that have established that maladaptive behaviors such as the use of alcohol and other substances can be passed intergenerationally. Maladaptive behaviors and related social problems such as substance use, physical and sexual abuse and suicide traumatize subsequent generations through learned behaviors which perpetuates the intergenerational cycle of trauma. Vicarious experiences of trauma through collective memory, storytelling and oral traditions become
embedded in the collective memories of the populations. This was illustrated in the collective stories of the co-researchers where they were taught to share in the ancestral pain of the NH ancestors. The original trauma of loss of lands, culture, people and language have been taught to subsequent generations. Additionally, subsequent generations also experience proximate experiences of injustice, poverty, discrimination and social inequality which becomes cumulative (Sotero, 2006). This author argues that the use of alcohol and other substances are learned behaviors that are also passed down to subsequent generations.

Walls and Whitbeck (2012), in a quantitative study of the multigenerational effects of relocation experiences on Indigenous family groups, focused on historical trauma as a contributor to AI health disparities, including alcohol use, and to the benefits of treating cultural loss as a source of stress. They examined the multigenerational effects of relocation experiences on AI family groups. The participants living on Indian reservations reported higher levels of drinking problems. The grandparent generations' relocation experiences were significantly associated with drinking, and the drinking problems were significantly associated with other substance use problems and depressive symptoms. A significant association found between intergenerational depressive symptoms, the effects of relocation programs, increased drinking and substance use, and lower rates of supportive parenting. The grandparent generations relocation experiences were significantly associated with drinking. Additionally, the drinking problems were significantly associated with other substance use problems and symptoms of depression.

The cumulative effects of colonization and historical trauma on the NH populations is mitigated to some degree by protective and resiliency factors that result in variable social problems that can lead to health disparities. Historical trauma is known as a disease of time. The
health of the NH population is the product of the accumulations of social distress from each subsequent generation.

**Understanding the impact of colonization and historical trauma.** The theme of understanding the impact of colonization and historical trauma is supported in the literature. All of the co-researchers' experiences were consistent with other studies on AIs/ANs and NHs in another context in Hawaii. Four quantitative and one qualitative study presented evidence that historical loss thoughts and discrimination are linked (Myra & Wieling, 2012; Pokhrel & Herzog, 2014; Tucker et al., 2016; Whitbeck, Adams, et al., 2004; Whitbeck, Chen et al., 2004). The impact of discrimination was found to be a trigger for historical loss thinking (Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004). Pokhrel and Herzog, (2014) established that the NH participants who experienced historical loss thoughts also re-counted experiencing discrimination from government officials. The literature supports that the most common type of discrimination included lack of respect, lack of courtesy, and being treated as less intelligent than others. Additionally, discrimination was also associated with the higher use of substances. In one qualitative study, the thematic findings regarding intergenerational vulnerabilities, the risk factors included discrimination, poorer mental health, and racism. The subthemes included traumatic memories of poverty and boarding schools for AIs (Myhra & Wieling, 2014). Tucker et al., (2016) found that perceptions of discrimination were directly related to depressive symptoms.

Pokhrel and Herzog's (2014) quantitative study of 128 NH college students examined the relationships between historical trauma, perceived discrimination and substance use including alcohol, cigarette, and marijuana use and 18 to 20% of the participants reported that their grandparents and great-grandparents were forced not to speak their Native language or practice cultural traditions forbidding hunting, fishing, and food gathering. The participants also
described being subjected to non-Natives visiting or living on NH lands. Eighty-one percent of the participants reported thinking about the loss of ancestral lands, 87% reported frequent thoughts of the loss of language, and 66% had frequent thoughts of the loss of respect and poor treatment by government officials. Between 12% and 15% reported frequent thoughts about the loss of respect from children for elders and traditional ways. The study demonstrated two pathways to substance use. One pathway led to higher substance use through perceived discrimination. Another more direct pathway led to lower substance misuse mediated by historical trauma. The study helped to establish that knowledge, experience, and thoughts that are associated with historical trauma could increase substance misuse behaviors because of increased perceived discrimination. Additionally, having pride in cultural heritage and identity could be protective against substance misuse and facilitate resilience.

In other studies, four quantitative and two qualitative presented evidence that historical loss thinking is linked with substance use (Myra, 2011; Myhra & Wieling 2014; Pokhrel & Herzog, 2014; Walls & Whitbeck, 2012; Whitbeck, Adams, et al., 2004; Whitbeck, Chen, et al., 2004; Wiechelt et al., 2013). Two quantitative studies using the HLS and the HLAS questionnaires, both of which with high internal reliability established that historical loss thinking prevalent among AIs is associated with the use of alcohol (Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004). Discrimination was found to be a trigger for historical loss thinking, and perceived discrimination was found to be positively associated with historical losses, which were positively associated with alcohol misuse in women. Wiechelt et al., (2012) established that participants with higher historical loss thinking had a higher probability of alcohol use within the past 30 days. Myhra and Wieling (2014) established that their participants reported having experienced many traumatic events related to the use of substances and experiencing a large number of traumatic events related to substance use by perpetrators. Also,
many of the traumatic events described by the participants involved both parents and children and were associated with the onset of alcohol misuse. Walls and Whitbeck (2012) established that drinking and other substance use was significantly associated with intergenerational depression symptoms, the effects of relocation programs, and lower rates of supportive parenting in AIs. Myhra's (2011) study on the intergenerational transmission of historical trauma among AIs and ANs established that the participants experienced continuing traumatic stress from historical trauma, trauma within families, racism, poverty, and poor health. Additionally, substance abuse was significantly associated with the impact of historical trauma and experiences of microaggressions and trauma within families. Goodkind et al. (2012) established that historical trauma could impact Indigenous groups within specific contexts, which affects perceptions and interpretations of experiences. Denham's 2008 study was one of the clearest responses to calls from scholars to focus on resilience articulated by researchers in the early 2000s. Denham’s (2008) study illustrated how multiple generations of one family by telling stories of traumatic events from previous generations incorporated the traumatic events into a framework for interpreting experiences and for achieving certain social goals. This study was one of the clearest responses to calls from scholars to focus on resilience that was articulated in the early 2000s (Balsam et al., 2004; Denham, 2008; Prussing, 2014; Walters, Mohammed, et al., 2001; Walters Simoni & Evans-Campbell, 2002). Enculturation had protective effects and facilitated resiliency (Whitbeck, Adams, et al., 2004; Whitbeck, Chen et al., 2004).

New Findings

Noesis and noema. The noesis or textural perceptions of the phenomenon were expressed through the thoughts and feelings of the co-researchers, which were described in detail in Chapter 4 in the discussion of the core themes, individual textural, and composite textural description. The noema or structural meanings of the phenomenon were expressed through the
universal structures of the time, space, bodily concerns, materiality, causality, relation to self, and relation to others (Moustakas, 1994). Finally, both the thoughts and feelings or textural descriptions of the co-researchers and the structures underlying their experiences were constructed through the process of imaginative variation into a universal or composite description of individual and structural textural description to illustrate the whole of the experiences of the phenomena under study. Findings which were supported in the existing database and Literature Review, Chapter 2.

New findings. This is the first qualitative study to look specifically at colonization, historical trauma and links to alcohol use in a specific context in rural Hawaii using Historical Trauma theory (Brave Heart, et al., 2011), Story theory (Smith & Lehr, 2011) the lens of the Historical Trauma Conceptual model (Sotero, 2006), and the Sociopsychological Explanatory model of intergenerational transmission (Gone, 2013) as guiding theories and frameworks.

The findings of the study are supported in the literature review. The experiences of NHs are similar to the experiences of other AI and AN tribes and groups despite the diverse geographic and cultural contexts. The main finding using the Historical Trauma Conceptual framework (Sotero, 2006) as a guide is that NHs like other American Indigenous groups continue to experience the consequences of colonization. Although it is well known that alcohol and methamphetamine use is prevalent in the NH community, a new finding of this study is the establishment of a link between colonization, historical trauma and alcohol use and other substance use. Additionally, methamphetamine, is easily acquired through the mail and has taken the place of alcohol as a substance of choice due to powerful effects and affordability. As with alcohol use, a link has been established between colonization and historical trauma and methamphetamine use. Several of the co-researchers expressed that both alcohol and methamphetamine are used by some NHs to mask feelings of losses, discrimination and poverty.
This is the first qualitative study to look specifically at colonization, historical trauma and links to alcohol use in a specific context in rural Hawaii through the theoretical lenses discussed above.

Another finding is that the student researcher's and the co-researchers’ experiences of colonization and historical trauma are very similar. The co-researchers were found to be strong and resilient preserving NH culture, language and health. The co-researchers have requested that more research on alcohol and methamphetamine be conducted in their community and culturally relevant interventions be developed.

This study has added to the existing knowledge base on how colonization and historical trauma affects Indigenous groups in similar ways. A link has been established between colonization and historical trauma, historical loss, and states of disharmony, both physically and psychologically, in NHs as with AI and ANs. It has already been established that Indigenous groups experience considerably higher rates of physical and mental health disparities, and alcohol and other substance use than other populations. This study established a link between colonization, historical trauma, and alcohol and methamphetamine use in NHs in a particular rural context. Another significant finding that needs to be illuminated is that the introduction and regulation of alcohol was a force in colonial expansion in Hawaii along with the spread of infectious diseases as with AIs and AN tribes and groups.

**Limitations**

The results of the study are subject to various limitations. First, the sample size is small and conducted in a single context, and the area where the research was conducted is somewhat geographically isolated as compared to the rest of Hawaii. The generalizability of the research findings may be affected by this limitation and should be done with caution. Another limitation of the study is that the sample size included more women than men. The data analysis did
support that saturation was reached, which was supported by the Pearson Similarity Coefficient index as evidence of significant similarity and overlap of all of the interview transcripts. Even though ten co-researchers were recruited, it is uncertain if a larger sample size could have added to the number of core themes. It might have been beneficial to have a larger sample size. Lastly, another possible limitation is that the student researcher either knew or indirectly knew the co-researchers. However, the qualitative method chosen for the study, the Stevick-Colaizzi-Keen method allowed the experiences of the student researcher to be included as part of the study. Before the interviews, the student researcher took a significant amount of time to reflect on and bracket her own personal experiences of the phenomenon under study with the explicit purpose of setting aside any presuppositions and judgments when hearing the NH stories.

**Implications and Recommendations**

Despite the limitations, this study is significant for several reasons and has great implications for future research, practice, and policy development. It is the only study that has specifically utilized Brave Heart et al.'s., (2011) Historical trauma theory, Sotero's (2006) Historical Trauma Conceptual model, Kirmayer and Gone's (2006) socio-psychological explanatory model and Story theory (Smith & Lehr, 2011) and storytelling methodology to explore the impact of colonization and historical trauma and links to alcohol use among NHs in a geographically isolated context. Additionally, the study includes a brief history of the introduction and regulation of alcohol with AIs and NHs and its role in facilitating the colonization of Indigenous lands.

AIs/ANs/NHs have experienced devastating collective group trauma. Trauma has been transmitted intergenerationally through more than one mechanism including oral traditions and storytelling. Biological mechanisms were not addressed in this study. There is increasing evidence that the emotional responses to collective trauma experiences and losses among
Indigenous peoples can help inform methods of reducing psychological suffering through the development of culturally appropriate interventions and treatments. It is important to take into consideration Indigenous group regional differences and how the trauma is experienced and also how trauma is experienced by individuals within groups and how these symptoms might be addressed. Notably, the cumulative effects of historical trauma in NHzs is mitigated by the existence of resiliency and protective factors that are unique to them. The findings of this qualitative study can be considered as contributing to the current knowledge base on the impact of colonization and historically traumatic experiences as an underlying predictor of alcohol and other substance use among American Indigenous populations.

**Clinical Implications**

**Current practice concerns.** Current practice concerns include addressing the shared experiences of collective trauma. Some Indigenous groups have suffered a greater number of traumatic events than others. Though there are differences among Indigenous groups on how or to what degree collective group trauma is experienced, there are also similarities, both of which are illustrated in this study. Indigenous peoples share a collective history of colonization, genocide, oppression, and racism. Interventions and research must simultaneously respect the collective philosophy and Indigenous group differences (Brave Heart et al. 2011).

Multilevel, systemic evaluations are needed to assess Indigenous communities for collective trauma, communal oppression while observing cultural distinctions between groups when measuring trauma responses and unresolved grief. While there is a need to evaluate communities, there is also the need to develop individual and family interventions. This process would involve gathering more exploratory data, such as this study. The interventions have to be developed in partnership with the Indigenous community members as advisors and consultants.
The Indigenous community members would function as co-researchers when the intervention is tested and refined through research (Brave Heart et al. 2011).

In their studies of PTSD among a Southwestern tribe, Robin, Chester, and Goldman (1996) recommended that there is a need to study the collective trauma of specific tribes or groups related to historical trauma and the continuing impact of discrimination, racism, and oppression. Also, Indigenous youths may demonstrate higher thresholds for PTSD due to chronic exposure to severe trauma. Additionally, cultural manifestations may vary among individuals, and PTSD screening instruments may be biased and unreliable. The intent of historical trauma theory, as developed by Braveheart et al. (2011), was to be able to frame current trauma exposure within the context of historical trauma and to decrease individual responses to trauma by illuminating intergenerational collective trauma with the intention of fostering healing.

**Implications for use of the HLS and the Historical Loss and the HLAS.** Whitbeck, Adams, et al. (2004) and Whitbeck, Chen et al. (2004) developed the Historical Loss Scale (HLS) and the Historical Loss and Associated Symptoms scale (HLAS) which moved the field forward in terms of scientific inquiry. The development of these two instruments helped to demonstrate a link between historical trauma and a collective historical past with the associated emotional experiences of HTR, which are accumulated through a lifetime of trauma. The HLS scale assesses the frequency with which people think about historically traumatic events and losses. The HLAS was designed to capture the emotional responses to these losses. As previously discussed in Chapter 2, the Literature Review, Whitbeck, Chen et al. (2004) found that a higher score of perceived historical losses, the more likely the individual was to report depression and anger associated with the losses. If these scales were used to assess for trauma in other Indigenous groups, it would increase the knowledge base of the prevalence of historical trauma and HTR among these groups. In order words, these scales can be used to assess the
frequency of historical loss thinking and the emotional responses in AI tribes or NH and AN groups that have not been studied yet. Pokhrel and Herzog (2014) used these scales to assess in a quantitative study the frequency of historical loss thinking in NH college students and their emotional responses and substance use. Their study findings were that perceived discrimination mediated the effects of historical trauma on substance use. Also, that perceived discrimination was a predictor of substance use, which was discussed in Chapter 2, the Literature Review.

**Implications for the use of the Indigenous Peoples of the Americas Survey (IPS).** The precedent for designing the Indigenous Peoples of the Americas Survey (IPS) was to examine collective group trauma while respecting diversity among Indigenous groups. The IPS is an instrument designed to inform clinical practice and research on the effectiveness of existing interventions that incorporate historical trauma and unresolved grief. The advantage of the IPS in clinical practice with Indigenous groups is to be able to combine other structured measures and assessments into the survey, including the HLS and HLAS, with the addition of other items that provide details about tribal identity, trauma experiences, depression and PTSD symptoms. The IPS was also designed to explore tribal and group diversity and their experiences of historical trauma. To help facilitate healing, which can be tailored to fit the specific needs of tribal groups. The development of the IPS was an effort to fill the gaps in knowledge of historical trauma experiences. Moreover, the IPS also requires a more detailed trauma history and the collective group trauma across the lifespan of Indigenous groups. The IPS can provide a better idea of the prevalence of HTR and symptoms across multiple Indigenous groups. Correspondingly, it would be helpful in the development of culturally relevant interventions to be able to identify constructs that may be generalizable to other Indigenous groups, and that could be used in clinical practice. Notably, the IPS asks individuals in specific Indigenous groups about specific losses they have
experienced as well as their perceptions about a collective past of trauma and prolonged unresolved grief (Brave Heart et al., 2011).

**Recommendations for Future Research**

The findings of this study have implications for future research. AIs/ANs/NHs have undergone devastating collective, intergenerational massive group trauma, trauma which has been compounded by racism, discrimination, and oppression and substance use, including alcohol and methamphetamines. Evidence of group and individual psychological and emotional responses to collective trauma and losses can help to inform a means to improve emotional and psychological suffering in these groups.

It is recommended that more research, both quantitative and qualitative, be conducted on the effects of colonization and historically traumatic experiences and the intergenerational transmission of historical trauma in diverse context-specific geographic regions. The research conducted needs to be driven by Indigenous groups and be culturally informed. Additionally, healing intervention models should be grounded in Indigenous worldviews with the aim to eradicate emotional distress that emerges as a legacy of historical trauma. Currently, the HLS and the HLAS do not include a full measure of depression or PTSD symptoms. The IPS is a step towards expanding measures to include both group and individual responses to trauma. Because Indigenous group differences can impact how the effects of historical trauma are experienced, long term historical trauma interventional research is needed to find interventions to reduce psychological and emotional suffering that is group and context-specific. Research would be strengthened by expanding and developing new measures that can be tailored to individual Indigenous groups through participatory research (Brave Heart, 1998; Whitbeck et al., 2002; Whitbeck, Adams et al., 2004, Whitbeck, Chen et al., 2004).
The long-term goal of historical trauma research is to develop culturally relevant interventions that are informed by the communities to improve the quality of life and empower Indigenous peoples to reclaim traditional knowledge, their identity, and health and to help to heal communities so that they are unburdened by grief over historic losses. Additionally, Pokhrel and Herzog (2014) highlighted the importance of further studying perceived ethnic discrimination in the context of historical trauma. It has been increasingly recognized that different Indigenous groups that have experienced collective trauma, racism, and oppression must begin to heal within their specific cultural context (Pokhrel & Herzog, 2014). Additionally, more context-specific research is needed to validate the historical trauma model, which has implications for healing and prevention. Thoughts and awareness of historical trauma may not be harmful to health if the issues that are associated with them are addressed and individuals within a group who have experienced the transmission of intergenerational trauma are provided with the resources and tools to manage the stress that is associated with it (Brave Heat et al., 2011).

Thus far, most historical trauma research has been conducted on a few AI and AN tribes and groups. Empirical research is needed to determine the existence of historical trauma and variations in responses in other American Indigenous groups that are dependent on the intensity of the trauma, individual group experiences, the context, and length of the trauma exposure, and the amount of time passed since the trauma occurred. Empirical research is needed to fully understand, validate, and operationalize the theoretical constructs of historical trauma conceptual model and to link them to health outcomes. Moreover, research is needed to evaluate the effectiveness of current intervention programs. Additionally, resiliency and protective cultural factors need to be explored in individual Indigenous populations.

**Recommendations for Policy Development**
Historical trauma theory is a valuable conceptual framework whose application to public health has great value in susceptible Indigenous groups who have been subjected to the forces of colonization. The model is rich in variables and is intended to help practitioners and researchers gain a better understanding of health disparities in Indigenous groups. The conceptual model can aid in the development of methods and policies for improving the health status of Indigenous people in the U.S., both at the population and individual levels.

To date, many Indigenous people have felt that modern epidemiology has, in large part, encompassed a paradigm that blames the victim, and produces interventions that have been harmful to Indigenous peoples. Health policies need to continue to focus on changing the intervention programs to integrate historical trauma theory with context-specific community support and involvement. The programs should be culturally appropriate and respectful of Indigenous people's self-understanding of historical trauma and the impact on the health of their communities and on individuals in their communities. Furthermore, it is important to address the characteristics of historical trauma that lead to substance use, medical co-morbidities, mental illness, and domestic violence from a non-Western paradigm. Western paradigms are fraught with cultural biases. The work that has been conducted in AI/ANs and now NHs provides a model for addressing health disparities in other Indigenous and minority populations using the Historical Trauma Conceptual Framework, which is focused on cultural sensitivity (Sotero, 2006).

**Chapter 5 Summary**

Chapter 5 presented a discussion of the results of the study in relation to the Literature Review, the conceptual orientation, the limitations of the study, and the implications and recommendations for future research and policy development. The results or core themes of this study are similar to those that have been experienced with AIs and ANs. The knowledge
generated is new knowledge in the sense that the Historical Trauma Conceptual model was used as the guiding framework for the study. This study is not meant to imply that NHs are weakened or disabled by experiences of colonization, but that traumatic experiences have impacted them. The effects of colonization results in conditions that affect the psychological, social, economic, political, intellectual, physical, and spiritual realms of AIs/ANs/NHs. History provides a narrative within which current social issues can be interpreted and by integrating a rich understanding of Indigenous history into social science research on health. As researchers, we can improve the cultural relevance of research findings and enhance interventions. NH history, as with AIs and ANs includes colonization, trauma, and the introduction of alcohol and now other substances, including methamphetamine. The question becomes in what ways do Indigenous people respond to history in order to help promote and support resilience. The addition of a story theory can offer a framework for analyzing how colonization and historical trauma and links to the use of alcohol have been transmitted and connected to present-day contexts.

Historical trauma is complicated in antecedents. In Hawaii, the antecedent was the arrival of Captain Cook and his crew at the peak of the Hawaiian political and economic success in 1778. The consequences of contact with Westerners impacted NHs psychologically, biologically, and culturally. It can be said that Westerners used an approach in how they colonized Indigenous lands for power and economic gain without concern for the consequences of the Indigenous people who were already here. NHs like AIs and ANs have experienced centuries of cumulative trauma and endured multiple traumatic experiences which have been passed on to subsequent generations through storytelling and social and biological intergenerational mechanisms (Sotero, 2006). This study did not address the biological transmission of the sequelae of historical trauma. The theory of historical trauma assumes that the descendants of the individuals who have
experienced historical trauma are more susceptible to pathological and psychological dysfunction such as PTSD, depression, anxiety, and alcohol and other substance use as a result of the experiences their ancestors endured. Historical trauma theory has provided a powerful explanatory framework that goes beyond the current social determinants of health. It provides a framework that goes well beyond a single lifetime and consolidates and proposes a model that can explain the dichotomy or chain of causality between the colonial agents of oppression and oppressed Indigenous groups. The theory of historical trauma puts into context both time and place and allows for the empowerment of Indigenous groups and individuals. It provides a framework to address the root causes of poor health. It allows for healing practices to occur that are unique to specific Indigenous cultures. More empirical research, both quantitative, qualitative and interventional is needed on other Indigenous and minority populations to determine the presence of historical trauma and trauma response variations that are dependent on the context and length of exposure, intensity, amount of time passed since exposure and on the protective cultural factors and resilience factors.
EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA

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EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA


EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA

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EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA


EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA


EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA


EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA


EXPLORING A SHARED HISTORY OF COLONIZATION, HISTORICAL TRAUMA


http://dx.doi.org/http://dx.doi.org/10.1037/cdp0000055


Aloha! My name is Cynthia Greywolf and you are invited to take part in a research study. I am a graduate student at the University of Hawai'i at Mānoa in the Department of Nursing. As part of the requirements for earning my graduate degree, I am doing a research project.

**What am I being asked to do?**

If you participate in this project, I will meet with you for an interview at a location and time convenient for you.

**Taking part in this study is your choice.**

Your participation in this project is completely voluntary. You may stop participating at any time. If you stop being in the study, there will be no penalty or loss to you. Your choice to participate or not participate will not affect you in any way and there will be no retaliation for not participating in the study.

**Why is this study being done?**

The purpose of my project is to gain insight in the lived experience of the phenomenon of colonization/historical Trauma and links to the current use of alcohol use among Native Hawaiians living in a rural area of Hawaii. I am asking you to participate because you are Native Hawaiian and have lived all or most of your life in this area of Hawaii.

**What will happen if I decide to take part in this study?**

The interview will consist open ended questions. There will no set time limit to honor the Talking story storytelling tradition. The interview questions will include 7 open-ended questions like:

1. What do you know about the history of the State of Hawaii and are there any stories that have been passed down in the area you live in since the arrival of Captain Cook in 1778?
2. What do you know about the health of Native Hawaiians as compared to other ethnic groups living in Hawaii today?
3. What do you know about the Native Hawaiian health status when Captain Cook arrived in Hawaii compared to the health status of Native Hawaiians now?
4. What do you know about alcohol use by Native Hawaiians in your area currently?
5. Have the kupuna ever talked about alcohol usage when they were growing up?
6. Have you ever heard anyone use the word “colonization” and if so what does it mean to you?
7. Have you ever heard of the words “historical trauma” and if so what does that mean to you?

With your permission, I will audio-record the interviews so that I can later transcribe and analyze your responses. You will be one of about 6 to 10 people that I will interview for this study.
Appendix A
University of Hawai‘i
Consent to Participate in a Research Project
Cynthia Greywolf, DNP-PMHNP, Principal Investigator
Project title: Talking Story with Native Hawaiians Living in a Rural Area of Hawaii to Explore Links between Colonization/Historical Talking Trauma and Alcohol Use in the 21st Century

What are the risks and benefits of taking part in this study?
I believe there is little risk to you for participating in this research project. There is some possibility that you may experience some emotional discomfort and that you may become stressed or uncomfortable answering any of the interview questions. If you do become stressed or uncomfortable, you can skip the question or take a break. You can also stop the interview, or you can withdraw from the project altogether. If you do experience emotional distress as a result of participating in this study you can seek assistance through one of the mental health resources on the list that will be provided to you or through your private provider. There will be no direct benefit to you for participating in this interview. The results of this project may help to improve the problems that have been associated with the effects of colonization/historical trauma that may be associated with alcohol use in the Native Hawaiian community and in the future development of alcohol treatment programs that treat alcohol use problems that are based on the Native Hawaiian communities’ input and the information that you have provided.

Privacy and Confidentiality:
I will keep all study data secure in a locked filing cabinet in a locked office/encrypted on a password protected computer. Only my University of Hawai‘i advisor, Dr. John Casken and I will have access to the information. Other agencies that have legal permission have the right to review research records. The University of Hawai‘i Human Studies Program has the right to review research records for this study.

After I write or transcribe a copy of the interviews, I will erase or destroy the audio-recordings. When I report the results of my research project, I will not use your name. I will not use any other personal identifying information that can identify you including the area of Hawaii that you are living in. I will use pseudonyms (fake names) and report my findings in a way that protects your privacy and confidentiality to the extent allowed by law.

Compensation:
You will receive a $25 gift card to local pharmacy or sundry store for your time and effort in participating in this research project.

Future Research Studies:
Identifiers will be removed from your identifiable private information and after removal of identifiers, the data may be used for future research studies and we will not seek further approval from you for these future studies.

Questions:
You are welcome to ask questions before signing this informed consent. If you have any questions about this study, please call or email me at [808-658-1992 & cynthiat@hawaii.edu]. You may also contact my advisor, Dr. John Casken, at [808-956-5750 & casken@hawaii.edu]. You may contact the UH Human Studies Program at 808.956.5007 or uhirb@hawaii.edu.
Appendix A
University of Hawai‘i
Consent to Participate in a Research Project
Cynthia Greywolf, DNP-PMHNP, Principal Investigator
Project title: Talking Story with Native Hawaiians Living in a Rural Area of Hawaii to Explore Links between Colonization/Historical Talking Trauma and Alcohol Use in the 21st Century

discuss problems, concerns and questions; obtain information; or offer input with an informed individual who is unaffiliated with the specific research protocol. You may also contact me using the contact information listed above if you wish once the data has been transcribed to see if what you have said has been correctly interpreted. Please visit http://go.hawaii.edu/jRd for more information on your rights as a research participant.

If you agree to participate in this project, please initial, sign and date this signature page and return it to Cynthia Greywolf, the student investigator.

Keep a copy of the informed consent for your records and reference.

Signature(s) for Consent:

I give permission to join the research project entitled, “Talking Story with Native Hawaiians Living in a Rural Area of Hawaii to Explore Links between Colonization/Historical Talking Trauma and Alcohol Use in the 21st Century.”

Please initial next to either “Yes” or “No” to the following:

_____ Yes  _____ No  I consent to be audio-recorded for the interview portion of this research.

Name of Participant (Print): ___________________________________________________

Participant’s Signature: _______________________________________________________

Signature of the Person Obtaining Consent: _______________________________________

Date: ________________________________  Mahalo!
Appendix B

Demographic Data Sheet
(To be stored separately from informed consent)

Pseudonym: ____________________________ (To be assigned by student investigator. This pseudonym will also be used for the audio recording of the interview and for the transcribed interview).

Date of interview: ____________________________

Location of the interview: ____________________________

______ Part Hawaiian Ancestry (self-reported).

______ Full Hawaiian Ancestry (self-reported).

______ Are your family roots from this area of Hawaii?

______ Approximately the number of years living in this area of Hawaii.

______ Female

______ Male

Age range

______ 30 – 39,

______ 40 - 49,

______ 50 – 60.

Education: What is the highest level of school you have completed?

______ No schooling completed,

______ Nursery school to 8th grade,

______ Some high school, no diploma,
Demographic Data Sheet

(To be stored separately from informed consent)

_____ High school graduate, diploma or equivalent, (GED),
_____ Some college credit, no degree,
_____ Trade/technical/vocational training,
_____ Associate degree,
_____ Bachelor’s degree,
_____ Master’s degree,
_____ Professional degree,
_____ Doctoral degree.

Marital Status:
_____ Single, never married,
_____ Married or domestic partnership,
_____ Widowed,
_____ Divorced
_____ Separated,

Employment Status:
_____ Employed for wages,
_____ Self-employed,
_____ Out of work, looking for work,
_____ Out of work, but currently not looking for work,
_____ A homemaker,
_____ A student,
Demographic Data Sheet
(To be stored separately from informed consent)

_____Military,
_____Retired,
_____Unable to work.

Thank you!
Interview Guide

Aloha, my name is Cynthia. I am the student investigator for this study. My contact information is in the informed consent that you signed, let me know if you need my contact information again. Thank you for agreeing to participate in this study. Please remember that you only need to share information that you feel comfortable sharing. If you become stressed or uncomfortable during the interview, you may skip the question and take a break. You can stop the interview or withdraw from the project anytime. You may review a summary of the results upon completion of the project by contacting me. You will be provided with a $25 gift card to the local Pharmacy or sundry store as compensation for participating in this study. Do you have any questions before we begin?

Questions:

1) What do you know about the history of the State of Hawaii and are there any stories that have been passed down in the area you live in since the arrival of Captain Cook in 1778?
2) What do you know about the health of Native Hawaiians as compared to other ethnic groups living in Hawaii today?
3) What do you know about the Native Hawaiian health status when Captain Cook arrived in Hawaii compared to the health status of Native Hawaiians now?
4) What do you know about alcohol use by Native Hawaiians in your area currently?
5) Have the kupuna ever talked about alcohol usage when they were growing up?
6) Have you ever heard anyone use the word “colonization” and if so what does it mean to you?
7) Have you ever heard of the words “historical trauma” and if so what does that mean to you?

I am going to start the audio recording now and will be referring to you by your pseudonym. I understand that you are a resident of this area of Hawaii and are either part of full Hawaiian and that you have either lived all of your life or most of your life in this area. I would like you to tell me more about your experiences from your perspective. I am going to ask you some questions to begin. There will be no time limit on the interview.
Appendix D

This is to certify that:

**cynthia greywolf**

Has completed the following CITI Program course:

- Social and Behavioral Responsible Conduct of Research (Curriculum Group)
- Social and Behavioral Responsible Conduct of Research (Course Learner Group)
- 1 - Basic Course (Stage)

Under requirements set by:

**University of Hawaii**

Verify at [www.citiprogram.org/verify/?w6021d1b9-415f-41e4-acca-58cc7edb5194-10904770](http://www.citiprogram.org/verify/?w6021d1b9-415f-41e4-acca-58cc7edb5194-10904770)
Appendix E

This is to certify that:

**cynthia greywolf**

Has completed the following CITI Program course:

**Information Privacy Security (IPS)**
**Non-Exempt Social & Behavioral Sciences Researchers and Key Personnel IPS**
1 - Basic Course

Under requirements set by:

**University of Hawaii**

Verify at [www.citiprogram.org/verify/?wd4fe3c65-c0d5-498c-bbd3-f45a74ee8a10-31722730](http://www.citiprogram.org/verify/?wd4fe3c65-c0d5-498c-bbd3-f45a74ee8a10-31722730)
Appendix F

CITI PROGRAM

Completion Date 20-May-2019
Expiration Date 19-May-2022
Record ID 29748877

This is to certify that:

John Casken

Has completed the following CITI Program course:

Human Subjects Research (HSR)
Non-Exempt Social & Behavioral Sciences Researchers and Key Personnel
2 - Refresher Course

Under requirements set by:

University of Hawaii

Verify at www.citiprogram.org/verify/?wc3e37375-b7d0-4403-b1f7-563f32af404a-29748877
Appendix G

Construction of Core Themes using Verbatim Dialogue from the Co-researchers’ Stories

Core theme 1: Unresolved grief over losses. Unresolved grief over losses was the most universal theme that the co-researchers described in their unfolding stories.

Student researcher (unresolved grief over losses). “Some of the history of the Cherokee I have heard from family stories and some from researching Cherokee history over many years. Hernando DeSoto, the Spanish explorer, discovered the Cherokee in 1540. Most of the stories that I have heard have always been about the Trail of Tears and after. Most of our Cherokee family history is lost. Cherokee lands had great value to the colonizers for farming and resources. However, it was in 1828 when gold was discovered on Cherokee lands that President Andrew Jackson signed into law the Indian Removal policies. These policies were enforced in 1838 and 1839. Indians were placed into stockades and force-marched 2200 miles, in the case of my family, they were relocated to northeastern Oklahoma in what is known as Indian country. The only survivor in my family that I am aware of was my 13-year-old great, great grandmother. Most deaths on the Trail of Tears were caused by exposure, disease, and malnutrition. She survived because a U.S. Marshal took care of her after the death of her parents, my great, great, great grandparents. Our family still carries the Marshall’s name. Some speculate that he may have been our great, great grandfather.

The original homelands of the Cherokee are in the southeastern part of the U.S., including Georgia, North and South Carolina, and Tennessee. My family is part of the Wolf Clan. My grandmother used to tell me that the Cherokee were considered the most civilized of the five tribes, Cherokee, Choctaw, Chickasaw, Muscogee (Creek), and Seminole. I used to think that being part of the most civilized tribe was something to be proud of until I began to understand what it meant. When I did realize what it meant, I felt angry. I began to understand
that it meant that the Cherokee were considered to be primitive and savage until they adopted Western culture."

"The Cherokee, like other Indigenous people, experienced catastrophic losses. Losses of people from infectious disease epidemics, alcohol, and violent aggression from Europeans who colonized Indian lands and forcibly took the lands away by any means possible. The losses and hardships didn't stop after the Cherokee were removed to Oklahoma. President Grover Cleveland signed into law the Dawes Act of 1887, better known as the Dawes Allotment Act. The law authorized the U.S. government to survey Indian lands in Oklahoma and divide them into allotments for individual Indians with the caveat that those who accepted would receive U.S. citizenship. This was an aggressive attempt for the U.S. government to allow White settlers to acquire Indian lands. The purpose of these policies was to abolish tribal and community land ownership rights and to make Indian lands available to others or to transfer lands that were under Indian control to White settlers. The objective of the Act was to assimilate Indians into mainstream society and to eliminate cultural and social traditions of which I am a product of. My grandfather, his brothers, and sisters are among those who received Dawes Commission roll numbers and land allotments.

I recently bought a book from Cherokee Nation and found my grandfather's and his brothers’ and sisters' (my great uncles and aunts) Dawes Commission roll numbers. Afterward, I went to the cemetery where I found their graves and sat under an Oak tree and spent the afternoon with them reflecting on their experiences and losses. As I sat there, I remembered how before 1978, we couldn't practice traditional ways. I remember being told that both the Redbird and the Stokes-Smith’s Stomping grounds where we practiced traditional Stomp dances were hidden out of plain sight because it was illegal. As a child I used go in the summers once a month mostly to the Stokes-Smith’s Stomping grounds with my grandparents and other family
members in an old wagon pulled by a workhorse and mule. It was several miles on a dirt road to the stomping grounds. We weren't allowed to speak the Cherokee language either, so we weren't taught. My grandfather spoke Cherokee on rare occasions, but he never spoke it to us. I saw him speaking to some of his brothers and to other Cherokees occasionally. I remember that he practiced more traditional ways than Christianity and he taught me some traditions before he died. My story is similar to the co-researchers’ who agreed to participate in this study."

**Co-researcher 1 (unresolved grief over losses).** "The stories that been passed down from my family was that us Hawaiians used to have plenty land. So, like my family, my grandma told me that our land is pretty much where the airport is. Oh. Yeah. That whole airport is our land, but they took it from us. We couldn't speak our language too. They try take away our culture too. I know many, many Hawaiians died. We used to have plenty people here. Yeah. It's pretty much, that's all I know."

**Co-Researcher 2 (unresolved grief over losses).** “Well, we lost plenty people after he (Captain Cook) came. We used to have millions of people here, but after he came, we lost our lands, our language, our culture. We Hawaiians died from diseases he brought too. They took everything from us. I know we should not be a part of the United States. No, we shouldn't. They just took our land. You see that big house over there? That house is owned by a haole here. He doesn't care about Hawaiian people. That land he lives on was given to my family during the Great Mahele, and that house isn't supposed to be there. That should be my house. It belongs to my family because it was our land. They take our lands, our language, and they almost kill us. Now they kill us at the community health center. For what? So, they can take our lands. Before Hawaiians didn't like own land. It belonged to all of us, but not to them. It has to be mine, mine, mine. They take everything for themselves. Some want all haoles to go home, back where they
come from, to leave us alone, to get off our islands, to give it back. Look what happened to Oahu? We don't want that here. We used to not have to worry about rent or a mortgage."

_co-researcher 3 (unresolved grief over losses)._ “I know that before we became a state that they had banned our language, our religion, our culture. They took our lands. Right? And nobody could dance. Right?. They took away our religion and tried to replace it with theirs. Why? It really makes me angry. I guess they tried to Americanize us. They took away the Hawaiian language and all that stuff, and it's funny because I just started taking a Hawaiian language class because I want to learn. I want to learn more about my culture."

_co-researcher 4 (unresolved grief over losses)._ “When he (Captain Cook) came to the islands, I know there was a lot of changes. As far as the lifestyle of the people prior to Captain Cook coming to Hawaii, it was like a hierarchy, a type of kingdom kind of way of life where it was mostly like a monarchy, a king, and queen type of thing, you know. Also, came with Captain Cook's era, I know as far as some stories being passed down, that the Hawaiian Islands were colonized by the United States of America. You know the history about Hawaii being overthrown and the imperialistic kind that ruined our way of life? That's what the United States brought over to Hawaii; a democracy government type of living. So, I believe from when Captain Cook was here; their government system was slowly ingrained into the monarchy of the Hawaiian Islands. Before, each island was run by their own king. So, now come the United States, but since Captain Cook's arrival, you know it was different back then like millions of Hawaiians living here at that time when he came. So, when he came, you know, along came a lot of diseases that we were susceptible to; the Hawaiians living in those days. So, Hawaiians are very susceptible to diseases, which the majority of the population declined, or a lot of Hawaiians passed away because of the diseases. Captain Cook brought those with him with his arrival. The missionaries or the Christian way of life for us was adopted into the lifestyle, too, as compared to
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prior to his arrival. The Hawaiian people worshipped many gods. Some say this system is a more solid system compared to when Captain Cook came."

Co-Researcher 5 (unresolved grief over losses). “What can I say? We used to have a lot of land, and now we can't afford anything. Where do I start? Well, from Captain Cook’s time, it's significant how we changed for the worse, meaning that a lot of the families are now are broken. Many Hawaiians died from disease, and we couldn't speak our language too."

Co-Researcher 6 (unresolved grief over losses). “My understanding is that we used to have plenty people and a lot of land too. We lost many people because of diseases he (Captain Cook) brought. We used to have almost a million people, you know? After he came, we couldn't speak our language either; we are much worse off since he came to the islands and ruined everything for us Hawaiians. Now we have to buy land or wait to get homeland. Many never get it, you know. I've been waiting long time for that. We never owned land like now. It's hard here. There aren't many places you can work. Many Hawaiians leave their families and live somewhere else. We struggle here. We never had that before, you know. Mainland people coming here to live. They buy those big houses up there. Some don't stay long because they don't like it here too. It's not what they expect here. Right now, we Hawaiians are dealing with that telescope they are trying to put up on Mauna Kea. We don't want that; it's sacred land to us. Many of our people are buried there; they have no respect. It's offensive, and you know we never wanted to be a state either; they just overthrew our Queen."

Co-Researcher 7 (unresolved grief over losses). “What I know is that we lost land and plenty people and most of us; we don't speak our language anymore. The United States of America took our islands illegally. We shouldn't even be a state. Our Queen was overthrown by them. Now, look at what has happened here. There used to be over a million Hawaiian people, but many died from venereal disease brought by him (Captain Cook). They brought many other
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diseases, too, later. We almost all died, you know. You know, because the same thing happened to Native Americans too. They take our lands, our language, and now put us down like we're stupid! The lands belonged to everybody but now can't afford own land; too expensive to live here. Look at Oahu. Big buildings everywhere. We don't want that. Look at Mauna Kea. They want to try put another telescope there. Why can't they put it somewhere else? Why they have to put it there? We worshiped many gods, and that is where gods are; it's very sacred. We are protesting now. Some Hawaiians are learning about their laws to fight them on this."

Co-Researcher 8 (unresolved grief over losses). “When Captain Cook came, we had plenty people in Hawaii, but after he came, many people died from diseases he brought. I don't know, but I just know we had plenty people when he came. Since he came, we have no more land, too; they take our land. We have no more land, and we have to pay rent and mortgages now, and we didn't do that before. I've been waiting to get land; you know homeland property since I was very young, and haven't got it yet. They are very corrupt over there, you know (referring to the DHL, Department of Hawaiian Homelands). There are big houses all over the place, and we can't afford them. Also, I know we couldn't speak our language anymore. When the missionaries came, they didn't like the way we dressed either. They didn't like the way we danced. They didn't like our culture. So, they made everything we did bad. So, they told us we had to change everything. We had to speak their language and go to their churches and practice their religion and wear their clothes. Makes me angry! We shouldn't be a state either. Hawaii was taken illegally, you know. So, it doesn't really belong to the United States, and so we shouldn't be part of the United States. We shouldn't; they overthrew our Queen. We should be Hawaii; I don't know how we do that. If you look at Mauna Kea, it is just another thing they try take away. They already put many telescopes up there; now, they want to put up another one. Why? They never
asked us for permission if they can do this with any of them up there. We are trying to fight it right now."

**Co-Researcher 9 (unresolved grief over losses).** “I know that, after Captain Cook came to Hawaii, it was no longer Hawaii, we had to change how we lived, change everything about how we lived. So, a lot of things happened after Captain Cook came like our lands got taken away. After he came then many other haole people came, many people came after he was here; then more came and then more and more of them came. You know, King Kamehameha united all of our islands, and when he died, then our laws (NH Kapu system of laws) was taken away, and when they took away our laws, our culture just started to fall apart after this happened. The missionaries came around that time too. So, the other big thing besides that was we lost many people to diseases brought by them. I heard we had around a million people living in Hawaii at the time, and after he came, most Hawaiians died then. I think most died by the time the Queen was overthrown. Before everybody used the land and the land belonged to everybody, and no one ever went hungry.”

**Co-Researcher 10 (unresolved grief over losses).** “OK. Well, the first thing that I would say is that we should not be the State of Hawaii. We should have remained independent of the United States, and Hawaii was taken illegally. That's what I know. Our Queen thought that the United States government would do what was right and give it back to us because of aloha. We live by aloha, which means love one another. It means give. I'm also part Caucasian, so I can say this. Caucasian people think they need to own everything. Everything needs to be theirs. They think that they need to own that property; they need to buy this or that. That's how mainland people know what wealth is. The wealth that we have is how much we can give — totally different concept. We lost our lands to them. They took everything from us. We showed them aloha, and this is what they did. We use what we need for the day, and that is it. Then we go the
next day. Nothing goes to waste like the Native Americans. So that's the first thing I say since Captain Cook. Well, let's see. Ninety-four percent of my population has died. Over a million Hawaiians, ninety-four percent died in a hundred years since Captain Cook came. Eighteen eighty-seven, I think that's right yes, by 1887, ninety-four percent of our people died a hundred years later; they were gone. He (Captain Cook) brought bubonic plague, he bought brought venereal diseases; diseases that wiped out my people because we were never around them before. We were living off the land and being natural. So, I feel a lot of sadness, a lot of anger, which has been passed down. I think one of the main things also about that is the way we Hawaiians looked at sex was completely different. Mainlanders brought Christians missionaries who have a totally different view. You only have sex with the opposite sex and in certain positions and maybe only during certain times of the day. For Hawaiians, sex was fun. Sex was like if I wanted to have sex with someone, we would have sex. So back in the day, there was no rape. There was no molestation because if you were good at sex, it's a normal thing here. Look how we are now with sex. Look at what has happened to us with the cycle of violence when it comes to rape, molestation, child abuse. It's rampant. So. Captain Cook coming here was not good for the islands. Some people always say if not him, that somebody else would have taken it over. Well, why? Why couldn't they just let us be."

**Core theme 2: Excellent health before to the worst health after colonization.**

Excellent health before colonization to the worst health after colonization was the second most universal theme the co-researchers described of the five themes in their unfolding stories.

**Student Researcher (Excellent health before to the worst health after colonization).**

"The Cherokee people experienced massive losses of people from disease epidemics, alcohol, and violent aggression as the colonizers encroached on Cherokee lands, and forcibly took them away. Most Cherokee people, like other Indigenous people, died early from infectious
diseases acquired from Europeans. Some of these diseases, such as smallpox, were deliberately introduced with blankets that given to Indian people. Today, Cherokee people experience chronic health issues such as diabetes, hypertension, heart disease, arthritis, kidney disease, and cancer.

My family have these issues too. My family were assimilated into the lowest economic strata as most Cherokee were, and many continue to struggle economically. Most in my immediate family don't know what healthy foods are. The Cherokee people used to be healthy before colonization, and like other Indigenous people worked the land, hunted and fished for food. Discrimination affects mental health, as well. There is less discrimination than there used to be, but the scars are still there in my mother’s generation.”

**Co-Researcher 1 (Excellent health before to the worst health after colonization).** “The health? I mean, I didn't study this. I'm not too sure, but I think we Hawaiians were plenty healthy then. We used to eat a lot of fish, raw fish. Now what I know is we Hawaiians get plenty high blood pressure, cause I guess we eat plenty pork. We get high blood pressure, diabetes and arthritis, and gout too because we just eat a lot of bad food. So yeah. We have plenty problems. We used to have land, food, no worries, no high blood pressure, no diabetes.”

**Co-Researcher 2 (Excellent health before to the worst health after colonization).** “We didn’t have any problems like today. We were healthy back then. We had plenty good food. You know we used to have plenty people here, but many died because of diseases brought to us. What I was told through my grandparents and they were told from their grandparents was that our people were actually healthy people here. We now have all these mosquitoes, rats, and all that other stuff. We didn't have a lot of that stuff here, you know, like illnesses and diseases, those days people would eat like taro. People from the mountainside would grow the taro, and the people from the ocean side that lived down that area they would trade-off, you know with fish, and people just ate better and took better care of themselves, and of course, they worked all day...
long. They did things; they didn't just lie around like the young one's today, you know. I see our people not eating right. They just eat all the wrong stuff, and that's why so many of our people we have like diabetes, you know. And, you know, you've got to pay attention to that and change it. Just change it and eat better. You know, like me, I worked at it since I got into my fifties. My doctor told me I was borderline diabetic; so, I pay attention to that. I eat right. I keep my weight down. I try to exercise and walk around and do things and drink a lot of water. You just take better care of yourself, you know, but most of our people here they're not mindful of that. They just overly indulge in the food and alcohol, the drinking and smoking. So, it's just some, not paying attention, you know to what you should do to make it better for yourself. You know that's the sad part, we've been hit hard, but many are not listening. So, we must pay attention to these things, you know, to make it better for ourselves. Yeah? It's all about choices. Right?"

Co-Researcher 3 (Excellent health before to the worst health after colonization). "I know we Hawaiians were much healthier back then than right now because we lived off the land. We went to the ocean to get our food. But I think with the mainlanders coming over from the United States, they introduced us to other foods. And I think that's where it began, the demise of the Hawaiian people. I think of their diet and now changes like you know, like with fast food and all of this stuff. That's why we are so unhealthy. The full blood ones that live off the land on Niihau are still healthy, but if they get diabetes or hypertension, they get kicked off the island. They have to go to Kauai to get medical care. Yes. If they get diabetes, hypertension, or any type of disease, they kick them off the land, off the island. My girlfriend said a lot of them come to Kauai because it's closer. Right now, we're all Polynesians because it's Samoans and Tongans, we're all part of the Pacific Islanders. Right? Even with the Samoan race once they got introduced to all the American fast foods and all of that, that's how they get hypertension, diabetes and then they come on over from Samoa to Hawaii. They all migrate here for health
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care. Okay. Because I work in the health industry, I'm a nurse, so I know it's really bad because of the foods that we eat. You know a lot of high-fat foods and then also with our culture, there's a lot of eating, everything you celebrate, and everything surrounds it with food. So, I know we have a high diabetes rate, overweight, and we have high blood pressure and heart disease. You know heart attacks, and then there's a lot of us on dialysis as well. It's like a big industry right now. It's all got to do with the food we eat."

Co-Researcher 4 (Excellent health before to the worst health after colonization). We Hawaiian people had perfect health before Captain Cook came and brought diseases. The Hawaiians were perfect in their health, and the reason why is because they were actively involved with the land. Yeah. I do know here there's a large majority of Hawaiians or being Hawaiian or being Indian or an Indigenous group, they're very susceptible to diseases. As far as high blood pressure, diabetes, and all of those types of diseases, as far as health, I asked a doctor one time about that subject. He was a doctor over here at the community health center. He actually does his own practice now. I did ask him, and he didn't have an answer. Right? But he said that a lot of Hawaiians here do have diabetes, have high blood pressure, and all of those things. But from what the doctor told me is that Indigenous people did well before Captain Cook came. The Hawaiians were perfect in their health, and the reason why is because they were actively involved with the land. So, the doctor told me the reason why a lot of Indigenous groups are susceptible is our bodies were not made to just sit down and watch TV all day. Right? Our bodies are made to work the land and to work the oceans. To be actively involved with physical things in our life. That's why the Indigenous people, you know they get all these diseases and stuff because they're not active and that's according to the doctor. Yeah. So yeah, that was quite a thing compared to other ethnic groups like living in Norway. Yeah I know for Hawaiians there's a lot more of the Hawaiian community that has more of the diseases like high blood pressure
diabetes, asthma and I'm not too sure what else. I know for sure diabetes and high blood pressure."

Co-Researcher 5 (Excellent health before to the worst health after colonization).” That's a tough question, but it’s fair. My understanding is that we Hawaiians used a lot of traditional healing, whether it be healing oils for massages, which I love versus contemporary Western medicine as we call it. A lot of Hawaiians will go to their traditional medicine when it comes to Western medicine. I think we were a lot better off before he (Captain Cook) came. I've seen a lot of our Hawaiians turn for the worst with Western medicine, and I know a lot of our Hawaiians were better off before he came. You know we didn’t have diabetes. We didn't have cancer. We didn't have high blood pressure. There was no such thing as diabetes. There was no such thing as cancer. There was no such thing as your rent is too high. You know there was no such thing. Now you know as we fast forward two centuries later, or whatever, and now we can't afford things. We have more problems than other people with our health. We have a lot more stress. Affects the mental health too.”

Co-Researcher 6 (Excellent health before to the worst health after colonization). “We were healthier back then. There was none of these diseases we have now. We were active back then and had plenty healthy food then too. Now us Hawaiians are not better off. We have diabetes, cancer, heart disease, high blood pressure; we didn't have this before. There was no such thing as these things. We’re susceptible to disease and have the worst health of anybody here. We used to have plenty good food, good health. We eat the wrong foods. That’s why we have all these things. Our health is not good.”

Co-Researcher 7 (Excellent health before to the worst health after colonization). "I know a lot of our Hawaiians were better off before. We have a lot of diabetes. We didn't have that before; we didn't have cancer. There was no such thing as diabetes and cancer. We eat food,
not good for us. We have stress because your mortgage is too high. You know there was no, there was no such thing as that. You can't afford gas for your car. There was no such thing as mental illness, but now there's depression too. We have suicides here too. We seem to have poorer health than anybody else here."

**Co-Researcher 8 (Excellent health before to the worst health after colonization).** “Well, it's like I say before when Captain Cook came, we were healthy people. We were strong people. We had plenty food. We used to work hard. We were active. Now we're not active. A lot of us don't have anything to do, and many don't have jobs here. We didn't have disease like now. We were always keeping busy back then. There was no fast food like today. Well, what I know is that we are obese. We have a lot of that, and we have diabetes, and we have heart disease. We eat a lot of bad food, like fast food. It's too expensive to even try to eat the foods that we used to eat. We have all kinds of diseases because our diet changed. Our foods used to be healthier than the foods that we eat now. Fast food it's cheap and convenient, and many of our people are dying from that. Other people in Hawaii have problems too, but it seems like us Hawaiians have the most problems than they have."

**Co-Researcher 9 (Excellent health before to the worst health after colonization).** “You know we were really healthy people as I understand it. We didn't even have any diseases back then. We didn't have any diseases at all. Like most of the things that we had back then, was like when we would injure ourselves, and most the time, we had our own medicines to help us get better. Now many people eat from someplace like a burger place. We got several around here, but at least we don't have McDonald's. But, most the time, it's a place like that. So, we eat a lot of foods that are bad for us. You know what they call Hawaiian food now isn't really good anymore either. It has macaroni salad with it, which I don't think is very good for you. We eat a lot of really greasy stuff, but it tastes good. What I know now is we Hawaiians are the sickest people.
So, I think we have more diabetes and heart disease and cancer more than other people. One thing I can tell you for sure is Hawaiians have diabetes. It seems like almost everybody here has diabetes. So many people now have to go to dialysis because they have kidney problems. We have a dialysis place here. The other thing that we have is a lot of heart disease, and many of us die from heart disease, and we have arthritis too. We have many things we didn't have before as I understand it."

*Co-Researcher 10 (Excellent health before to the worst health after colonization).* "Oh my gosh, we were strong back then. So, one of the things that was known is that before he (Captain Cook) came, the people were good to one another. If there was an issue, you know it was worked out. Nobody struck one another. Now we're trying to teach people not to do corporal punishment for their children because of the cycle of violence because they are going to hit you too. So, that was one of the things, mental health. But, so, and I'm talking about health that relates to health before Captain Cook came because the land was plentiful. There were no diseases. We had sex with who we wanted to have sex with, and when we wanted to have sex with them, we could, however, often we wanted, and if you were good at it and people knew you were good at it, they would just wait for you. But part of that, I think sex is a part of our mental health and being comfortable with whether we're gay or whether we're straight. There were Mahus then, and it was ok because that's what you were. So, there wasn't this judgment, it was a mix, and it was fine. But now, when you're going to compare today, we already had LGBTQ. We already had that. But it didn't matter; we didn't need clubs; it was just how it was. So, I think we were probably up in our prime when he (Captain Cook) came, and when he left, we weren't. Today I know our health is terrible. We are one of the most underserved populations. We suffer from diabetes, high cholesterol, and I would attest that too if you've heard of the ACE (Adverse Child Experience) tests which, if you score of four or more, you're at the risk of dying earlier.
Don't quote me. I don't know. Seventy-five percent for all of those things like high blood pressure, diabetes, overweight, suicidal ideation, you know, early pregnancies, the gambit is there. I think we're one of the worst on all of the scales, and I think part of that is what happened when Captain Cook came and eventually taking away our land. Like Native Americans where owning land is foreign. They want to own everything for their kids, right? Hawaiians, locals, want everyone to enjoy. So, I think that was major. I just think health is not good here. So, what else can I add to that.”

Core Theme 3: Alcohol and methamphetamine addiction are problems and are often used to self-medicate feelings of loss and discrimination. Of the five themes, this was the third most universal theme that the co-researchers described in their unfolding stories.

Student-Researcher (Alcohol and methamphetamine addiction are problems and often used to self-medicate feelings of loss and discrimination). “Alcohol introduced by Europeans is still a legacy among my family and the Cherokee people. The historical accounts are that it was deliberately introduced once the impact it had on Indians was realized. Alcohol is a legacy that continues to affect the quality of life. My Cherokee grandfather died from the effects of severe alcoholism and tobacco use and ultimately to suicide. No one really talked about it, but occasionally I would overhear my grandmother talking about it with my mother and other family members. Many in my family are alcoholics and are unable to tolerate drinking. One of my uncles' drinks moonshine regularly. He hides it in the yard where no one can find it. He recently told me that he gets it from the same family that provided it to my grandfather over sixty years ago. For him, alcohol is the only thing that helps take away his emotional pain. There were a lot of domestic violence issues in our family, especially when my grandfather was alive and drinking alcohol. The stories about him are legendary. The cycle of unresolved grief, sadness, anger, drinking, and violence continues in my family, and my uncle is a lot like my grandfather.
Other family members continue to have problems with alcohol and other drugs. The intergenerational transmission continues.

**Co-Researcher 1 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination).** “Alcohol? I know it calms down everyone's nerves. Everybody comes together as family and to gatherings to just party. So, every time I go to a party, we always have alcohol. The kupunas’ drinking too. Fun drinking. Ok. I drinking too. We stop before we get falling-down drunk. Oh, I see the drugs like meth. So, that's what I see that brings us down. Man, I never do that. I see many Hawaiians drink plenty alcohol, but the meth is one that now catches all the headlines. Right? Because you can see them on the beach. All the time on the beach and they're probably using. Since I was a kid, I've seen a lot of that already. So, it's been a while. All I know is that my grandmas tell me, don't do that. Told me don't touch that. You see someone do it you walk away.”

**Co-Researcher 2 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination).** "Well, when I was growing up in the fifties, it was like the norm, where the husbands would drink. They would just get so intoxicated that they would be abusive to their wives. It just seemed to be like a norm. That was really sad to see. So, when I grew up, I told myself I will never marry a man like that because I saw that you know. When I was young, you go to parties, and everybody's having a good time. Then one guy is just totally drunk, and then he starts beating on his wife, you know. So, it wasn't a really nice time at all, and I see it today as well. There's a lot of young people you know, they drink, and they do the same thing and abuse their girlfriends too. So, it's as though they really can't handle their liquor. But yet they make the wrong choices to continue to drink it and then I believe that's why a lot of our locals end up in trouble with the law and in jail because of all the wrong choices they make. So, I'm very fortunate that my sons are not drinkers. Maybe on a rare occasion, they'll
have a glass of wine or one beer. If somebody is saying well it's a special occasion that's ok as well and for myself too. We're just not much for drinking, and I love it that way. We are teaching my grandsons the same qualities and my granddaughters, you know. They'll teach their children as well instead of all this craziness that our people are exhibiting. You know it's really sad to see. But they just need to pay closer attention to detail and just make it better make a better choice. Yeah, but they do overindulge. A lot of Hawaiians do and can't handle their liquor. I think some do it because of all of the losses we have had, the lands, language, our people.'”

Co-Researcher 3 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination). "A lot of Hawaiians want to drink on the weekends when there's football. It's always part of the celebration, and that's why there's a lot of alcoholics here. It also comes into play with driving, and DUIs and people are killed, like that boy that passed away who was hit in Waianae. They did a big thing, and now they got a call on a bill for him because a girl that was drinking killed him. So, DUIs are big. A lot of people will get behind the wheel and drink and drive; drinking and driving that's a huge issue. Yes, especially here too. It's a big issue here. Ok? Well scary, very scary, and especially at night. Right? And just the beginning of this year, we had two more hit by drunk drivers in Hawaii. My God! We have a lot of domestic violence, too, from drinking here. I rarely drink now, but occasionally I do drink a little. I told my kids the same thing. Don't get to where you get belligerent, and you don't know what you're doing. You need to stop. Yeah. I think many Hawaiians drink and use meth because of emotional pain because we Hawaiians lost so much, and I think that some just party with it. I really believe so a lot. I believe that especially with the men too. Right? Hawaiians, they're pushed down, so they use alcohol. I just recently lost my fiancée, and he had a bad upbringing, and he dealt with a lot of demons. So, he did drugs. He did meth. He took meth for practically his whole life. Yeah, so, he got congestive heart failure, but you do all of that because
once somebody strips your identity, who you are, then it's hard because it brings down the self-esteem. So, I'm trying my best to feel like I'm worthy. I'm a good person. Yes. When you get people always knocking you down, it's hard, and I see that a lot in our community with a lot of the males. Right? Because you're expected to be a certain way, especially the men. Yeah, and that's what they do to cope is use alcohol or drugs. So, when I started my nursing career and I worked in a hospital and, you know, people would just look at me and say, "Oh, that's a dumb girl, or she's lazy or, she don't know nothing. I have encountered a lot of people who ask me, where is the nurse? And I'm like, I'm the nurse. They think I'm the nurse's aide, or I'm just the housekeeper or whatever. But I experience that a lot in my career here with my job. I believe in that work. Most people they just go by the color of your skin, you know, to define you. Another thing like when you come from certain areas that bad people come from. I'm like not all of us are bad, you know. Not all of us are homeless or living on the beach or taking drugs. Some of us are responsible adults, and we work. We work hard. But yeah. So that's another thing is the stigma. Yeah, sometimes I would cry. You know, just call my mom because I'm Hawaiian they think these things like I don't know nothing that I'm stupid. I'm not stupid. I'm educated, you know, for anyone. Even in schools, if you're not White or you're not Oriental, then you're nobody. You know it's sad. So, you know, like I can kind of relate to what Black people go through. Right? Well, you know, like the Mexicans, I mean the on mainland. Right? Right? Right? Even the Indians are not accepted if you're not White. Then you've got to work harder to prove who you are. It's hard to know you are worthy. I believe Hawaiian people use drugs or alcohol to cover up a lot of these feelings. I believe so."

Co-Researcher 4 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination). "In this area here, I know there is a lot of alcohol use among the Hawaiian people. There was a lot more use prior to the methamphetamine
influx into the Hawaiian Islands. A lot of Hawaiians used cocaine too before methamphetamine. Yeah, before methamphetamine came in, it was cocaine. Before, Hawaiians were heavily involved with drinking. Today they're switching to methamphetamine, and you know I'm a product of that too, but I've been clean for many years now. But I can tell you this, those who were alcoholics they won't go back to alcohol. That's because methamphetamine, it's really, really, powerful. It's really addictive. In terms of experience with both alcohol makes you go to sleep, methamphetamine keeps you up, and it gives you a lot of energy. You can do lot of things like tasks, jobs. You know it's like cocaine, but methamphetamine is more stronger. It can get you higher, and it lasts a long time. It's cheaper to use. It comes from Mexico. They import it. They send it through Federal Express or United States Post Office. They deliver it straight to you at home. Well, I know a lot of people that were alcoholics who are now drug addicts. They don't go back to drinking alcohol, not like before. They'll have one or two beers. They will just continue to smoke pot, but their main drug is methamphetamine."

Co-Researcher 5 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination). "A lot of the families now are broken because they don't know how to control themselves with alcohol. They also don't know how to say no, I've had enough. They need somebody else like the police to say they have had enough. An authority to tell them how to go home. Especially our younger generation, which hurts my heart. I personally took a stand in my own ohana. I don't drink, and I tell them, which is true, that I'm allergic to alcohol. So, they look they at me like what is the matter with you? So that's my personal thoughts. To set a change for the positive. I guess a lot of our younger generation, especially the younger ones, are like the older ones, like the kupunas. But, ok, so now methamphetamine kind of eked its way in there too. Right? After 1893 look at what happened. I mean, you could see there's a history of what happened with alcohol at that point with the laws."
Right? But what happened after that it was like they didn't care anymore because they already got the land. Right? So, it's like all of a sudden. It was like nobody did any studies. Nobody was looking at it. And then the Hawaiian research started to happen, but people are focusing on health trying to improve data points to help try to keep programs up. But then, I was looking at well, what about alcohol? What about that? What about some of these drugs still? All of this history stuff. I know the community health center is trying to get a NH program together. I'm not sure if they started it yet. You talk to my friend, and he can elaborate more on that. He's really good about that. He's in recovery from alcohol and meth. His testimony is amazing. He pretty much is really knowledgeable on this. What I can tell you is that alcoholism in our younger generation is really out of control almost as much as the meth is out of control. It's imported on a daily basis. Once we legalize marijuana, there's no way we Hawaiians can make a life. I mean, we need to get rid of it. So, drugs are here to stay if they do that. It's like the meth, the alcohol, plus the marijuana. And it's sad because of course now they keep interjecting new drugs all the time. You know it was alcohol, but now it's like alcohol is not the bigger issue. So, we've got to get something stronger. Let's get meth. Meth is more stronger. Oh, let's get marijuana, so they're legalizing these stronger stuffs instead of handling the situation. People are self-medicating away a lot of pain. Well, let me tell you that we have Hawaiians have people who are part of the military with PTSD. That's a whole other level of trauma. They self-medicate by smoking dope and having a beer, and then all of a sudden, you see the police department involved. It's all because we lost our land. Because somebody else took it and then they said get out. You're on my land. I don't want you. We had generation after generation on that land before."

Co-Researcher 6 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination) "We changed for the worse. There are many families with problems because they don't know how to control themselves with alcohol and
don't know when they've had enough. An authority has to get involved to tell them to stop. I don't drink. But our younger generation are like the kupunas. It's what our kupunas do — teaching the young ones how to drink alcohol and be like that. I think some of them drink because they are angry about what's happened to us Hawaiians. I say it's a habit too like my mom and dad drank. It was normal. No problem. However, what the kupunas were doing caused problems in my family by teaching the young ones how to drink. Now, they have domestic violence because they cannot handle their alcohol. They end up in jail too. I see a lot of people drinking alcohol here all the time.”

Co-Researcher 7 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination). “Hawaiian people use a lot of alcohol, but it used to be more. Mostly beer and it was used to be more before meth came. Many people like the meth better because it gets you high and you can't feel anything, you don't care as much about things. It's cheap and easy to get. Don't get me wrong. Plenty people still drink beer but like to use more use meth now. I don't to like drink anymore. I don't use meth anymore, but some family members have problems with alcohol and meth. They don't realize it, but we got kids being hurt because of it."  

Co-Researcher 8 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination). "Well, I know that Hawaiians drink plenty alcohol, especially here in this area. There's more alcohol, I understand used here than any other place in Hawaii. It's really bad. It used to be the most used thing here, but now there is meth. Meth is used more. People are starting to prefer the meth over the alcohol, but there's still plenty alcohol. You know we like big parties; we like to eat, and we serve plenty alcohol, so we like it for that. People always drink lots and lots of beer, but many people have problems from drinking. Before, you know, we had Okolehao, which was alcohol. I don't know whether we had
it before Captain Cook, though, but we had it. Alcohol has been a problem for long time, but now there are plenty other drugs like meth people use. There's not much else to do, and the meth makes you stay up for long time and makes you feel numb about things. That's what I've heard. I think that some people drink and use drugs to cover their feelings. You know many people are angry about everything."

*Co-Researcher 9 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination).* "Many people use alcohol. I think almost everybody uses alcohol and there are a lot of problems with it. You can see it. I have that problem in my family. My grandfather used alcohol, and he was very sick from it. Many of my family saw him drink alcohol, so they drink alcohol too. I don't drink alcohol. What happens a lot is you see grandpa will drink, and then he will drink too much, and then he will hit my grandma, and you see that happen a lot. You see a lot of domestic violence. So now we have to treat that because so many people you know do that. So that that's a problem for us Hawaiians. We have a lot of domestic violence because of alcohol. So, I don't know. I just know that that's what I see in our area here. And I know the police are always involved, and the police are always trying to stop people from doing their domestic violence, and people go to jail all the time because of it. What I also know is that a lot of people grow marijuana in places here. But I don't really have a problem with that so much. What I worry about is people using meth. Meth is a big, big problem. It's a bigger problem than alcohol. People prefer the meth over alcohol, which is going to make it even harder to stop now. I really don't know what's going to help."

*Co-Researcher 10 (Alcohol and methamphetamine addiction are problems and often used to numb feelings of loss and discrimination).* "Well, I do know that on this island, specifically, I think beer is actually sold at the cheapest in all islands per capita. We consume the most alcohol in all the islands, and on this island, there are many Hawaiian people. So, we are,
and I'd say we love our alcohol. Unfortunately, people use it as a coping mechanism for their pain about all of the losses we've had. Alcohol is a really big problem here, which causes a lot of violence because people bottle things up. What does it do? It allows you to do what you would want to do if you didn't know that's what you were doing. Right? And so, when people are in pain, they drink more and there's a lot of domestic violence on this island. We've had car accidents where people have died and killed themselves and other people, you know. So, yeah, our alcohol use is very high."

Core Theme 4: The kupuna teach the younger NHs to drink alcohol. Of the five themes, the kupuna teach the younger NHs to drink alcohol was the fourth most universal theme that the co-researchers described in their unfolding stories.

_Student Researcher (The kupuna teach the younger NHs to drink alcohol)."_ The stories that have been told in my family are that my grandfather and some of his brothers, he had 18 siblings, drank alcohol; almost all had severe alcohol use disorder. My grandmother told me that my grandfather's drinking got worse when he lost his land allotment in the late forties. His original land allotment was located on a prime piece of farmland next to the Illinois River near Gore, Oklahoma. The River and Harbor Act of 1946 authorized the building of Lake Tenkiller dam in 1947 for the purpose of flood control. The Tulsa District Corps of Engineers built the Lake Tenkiller dam. The sad part is that my grandfather worked for the WPA or the Works Progress Administration, which was established in 1935. It was a New Deal agency that provided employment. My grandfather had been employed to measure water levels on the Illinois river on his property for several years. The job provided much-needed income during the Great Depression. I don't think he knew that the purpose of measuring the water levels would lead to losing his land to build a Dam. The stories that have been passed down are that the land was taken by eminent domain because my grandfather didn't want to sell it. He tried to no avail to
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hold off the Tulsa District Corps of Engineers' bulldozers and the Law with a shotgun. He lost
the battle with the U.S. government and the Law. According to my cousin, my grandfather's
standoff is well documented as part of Oklahoma history and is archived at Oklahoma State
University in Oklahoma City. My grandfather was referred to as "a crazy Indian man with a
shotgun" in the records. The government did pay him fair market value for his land. They also
gave him a lifetime job as a night watchman on Lake Tenkiller. The job and the money were no
consolation to him. My grandmother had managed to use the money that was paid for the Gore
property to buy back one of my great uncle's land allotments. He had allegedly lost it in a poker
game. Grandma told me that grandpa never got over losing that land. He was an alcoholic, to
begin with, but his use of alcohol got much worse after this. I watched as my grandfather
suffered from bouts of depression and binge drinking. He would go on violent rampages, or he
would blackout in his bunkhouse or both. He had episodes of explosive rage, loss of control, and
violence when he was drinking. This often included shooting a .38 caliber pistol randomly at a
tree near his bunkhouse and around the house we stayed in. My grandmother was always afraid
that someone would get shot. We would have to leave the house when he did this, even at night,
and sometimes we had to hide in the pasture or go over to one of my great uncle's houses across
the highway. This was all normal behavior when I was a kid. It wasn't until I got older that I
realized how much danger we were all in. Grandpa committed suicide when he was sixty-two;
ten years after Lake Tenkiller dam went into operation. Ever since then and for as long as I can
remember, it has been a family tradition to look at the land that my grandfather lost to the
government. From my perspective, family members of my generation and older have never
really gotten over it. Also, the use of alcohol has been passed down. My uncle struggles with
drinking and binge drinking much the same as my grandfather with the same episodes of
explosive rage and violence and shooting at the same tree with a .38 caliber pistol. The legacy of all of the losses and alcohol is being passed down to his children as well."

**Co-Researcher 1 (The kupuna teach the younger NHs to drink alcohol).** "Well, you can say, my grandma, yes she knew about alcohol and drank it. I was the one grabbing them their beers and then grab them more beers later. Yes, it's fun to get together with family and drink but, okay, nobody had like that fall down drunk stuff going on much. But, if did, would pick them up and then they'd have to sit down and drink water early. Yeah, and then they go back drinking again. But I hardly see that. You know Mauna Kea? So up there they have the policy of no alcohol, no smoking, no anything. Everything has all got to be legal. I would find out more from the kupunas up there. The kupunas would really know. They really know the sacred land up there, you know, and about drinking."

**Co-Researcher 2 (The kupuna teach the younger NHs to drink alcohol).** “My grandfathers they were drinkers; they really were. My grandmothers, they weren't much for drinking at all. No, but they did say that they saw it used a lot back in those days, you know, and that's about all that I heard about. And, the kupunas say that when our Queen was overthrown, and the lands were taken away, it was taken away with a trade of rum and alcohol. The kupunas drink because of this, and now a lot of people drink because of what we lost."

**Co-Researcher 3 (The kupuna teach the younger NHs to drink alcohol).** “Like my mom's family were heavy drinkers. A lot of alcoholics on my mom's side. So as a child, that was what I surrounded with, and you know drinking having a good time; drinking with music and stuff. I drank at 13, actually. My mom let me have some wine and stuff, but it was just for you know as long as you can handle it. You know that Hawaiians used to have Okolehao, but I don't think it was a problem. What I know is that you get to a point if you can't handle it you need to stop drinking."
Co-Researcher 4 (The kupuna teach the younger NHs to drink alcohol). “All I know is my family advises me or encourages me to follow the Christian ways and not to drink or use drugs. So, I believe in following the Christian way. My family told us this because they loved us, and they did, and they wouldn't do anything to hurt us.”

Co-Researcher 5 (The kupuna teach the younger NHs to drink alcohol). “Our kupunas teach us how to drink. It's what our kupunas are doing — teaching the younger generation how to drink alcohol and be like that. Yeah, look when I say habit my mom and dad drank. Drinking was considered no problem whatsoever. However, there was a problem because as we fast forward with what some those kupuna were doing destroyed our family. They hit their wives. They have domestic issues. They have CPS (Child Protective Services) issues where the children are removed from the home because they cannot handle their alcohol. They end up in jail. You know, so, all these things end up leading up to it. We see a lot of people using alcohol here all the time. I mean, we got kids at the school that are affected because of what's going on. Where do you think they learn to drink? They learn to drink from their parents and the kupunas. Even on Hawaiian homelands, there's a lot of alcohol use. Now it's both alcohol and meth use. Ok, so, now guess what? Methamphetamines is a problem too.”

Co-Researcher 6 (The kupuna teach the younger NHs to drink alcohol). “The Kupunas are teaching the young ones how to drink. There are a lot of alcoholics, especially in my family. We grew up around it. I think that people drink alcohol because of all we lost. We were always looked down on too. I think that is why. Like I said, we have meth now. Used to be just alcohol. I think that maybe some of the kupunas may be using meth too now.”

Co-Researcher 7 (The kupuna teach the younger NHs to drink alcohol). “The kupunas are drinking alcohol, and the young ones learn from them. Yeah, drinking isn’t considered much of a problem, but I think it is. Meth is a big problem too. There are domestic violence problems;
problems with our kids. Some can't handle alcohol, and they end up in jail. I see a lot of people using alcohol all the time, including the kupunas. The kids in school are drinking and using meth, but I know they learn to drink alcohol from the parents and kupunas."

**Co-Researcher 8 (The kupuna teach the younger NHs to drink alcohol).** “Yeah, some of our kupunas use plenty alcohol. We have big parties and like to drink beer. That's part of it. It can be fun. I drink beer, but I don't get drunk. But yeah. The kupunas they drink and now the younger generation they drink too. They use a lot of the meth and marijuana too. But alcohol and meth are the big problems.”

**Co-Researcher 9 (The kupuna teach the younger NHs to drink alcohol).** “The thing I know is, I don't think we had alcohol before. What I know is that we had awa, but I don't think we had alcohol. The kupunas like I told you in my family drink alcohol and now the young one’s drink too. They drink mostly beer. So, that's a problem because they drink too much, and can't handle it and do things they shouldn't. And like I said sometimes the police have to come because people get really mean, they get into fights and there's a lot of domestic violence.”

**Co-Researcher 10 (The kupuna teach the younger NHs to drink alcohol).** “Let me think about that. Well, I guess I have to put that on my family, and I would say it's just a cycle like you know with my grandfather, and my uncle, who I would say is seventy. It's just normal to just drink, drink, drink, and you know they wake up wasted and drink again the next day. So, I think it's something when I look at that; it has been passed down. But we didn't have alcohol before Captain Cook, and now we do. And I think that's the way we deal with our pain and cultural trauma, historic trauma. You know we don't know how to deal with loss of land. You might as well kill me or us Hawaiians because that rock over there is my family and our family. But I'm infused with my ohana, my island. The land is my family. I think you go home, and boy, you know even if you were talking to kupuna in their eighties or nineties they're gonna tell you to
drink. You know come on if it's somebody else younger drinking there is going to be a fight, and then old uncle is gonna punch somebody too. It just would be like that."

**Core Theme 5: Understanding the impact of colonization and historical trauma.** The fifth theme understanding the impact of colonization and historical trauma, which some of the co-researchers were familiar with, and others were not familiar with the terminology but were familiar with the impact of colonization and historical trauma.

*Student-researcher (understanding the impact of colonization and historical trauma).*

“Lately, I have been reflecting on the NHs fight to preserve Mauna Kea. I have been reflecting on issues that involves me personally as a Cherokee in regard to the continuing impact of colonization. Through my reflections, I realized that Mauna Kea represents a metaphor for the some of my personal struggles with identity and identity appropriation by non-Indians. I grew up in a Cherokee family, but I struggle with identity because I am a product of assimilation as many Indians are. I am of mixed heritage. This is in large part because of U.S. policies, in this case, the Dawes Commission Act of 1887. Cherokee lands were removed from Indian control and were opened up to non-Indians. Individual allotments were distributed to Indians willing to accept U.S. citizenship. At this point, I am pretty sure there are no more full-bloods left in my family. I knew many growing up. The blood quantum decreases significantly with each generation. I am often asked by other Indians and non-Indians, "why are you and other Cherokees so White?" Under normal circumstances, I would typically ask them, "what do you think a Cherokee is supposed to look like these days?" The situation is confounded by identity appropriation by non-Indians. I hear it everywhere. It seems like everybody wants to be Cherokee for some reason. I used to mind answering the question, but not after Elizabeth Warren claimed to be Cherokee. At first, I was angry about Warren's claims. However, Warren's claims have turned out to be a blessing in disguise. Many people have come up to me throughout my
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life, claiming to be Cherokee, but without any vetting by any of the three Cherokee tribes. Warren's claim and Cherokee Nation's reply to her has created a platform for me to educate people about how different U.S policies affected different tribes. Cherokee Nation made a statement about how these claims by non-Indians, or people without affiliation to the Cherokee Nation or other tribes damages and threatens the sovereignty of the tribes. Cherokee Nation does not use blood quantum as a measure of who is a Cherokee as many other tribes do. Heritage is traced by direct descent through birth certificates to a family member who received a roll number during the Dawes Commission Act between 1893 to 1914. If blood quantum was a measure of being a Cherokee today, then Cherokee Nation would not exist in the numbers it has today. Some of the descendants of those who colonized Indians' lands and took everything from Indians continue to take no responsibility for what their ancestors did. Some of them continue to benefit from appropriating Indian identity and to cash in and make or take money at Indians’ expense.

The 2010 Census revealed that 540,056 non-Indian people claiming to be Cherokee. These individuals were not enrolled in any of the Cherokee tribes. The reality is that there are approximately 315,049 Cherokee tribal members including, 13,000 in the Eastern Band, 288,749 in Cherokee Nation, and 14,300 Keetoowah tribal members on the Census. It would be much more respectful for people to acknowledge that they have Indian heritage and not claim tribal affiliation and not to benefit financially from these claims."

Co-Researcher 1 (understanding the impact of colonization and historical trauma).

"I want to know more about what happened to us. I never heard of those words (colonization, historical trauma) before. But I want to understand. I want to know more about that too. Now, after this, I want to know more. I know they are trying to put up another telescope on Mauna Kea. That is historical trauma. Thank you for making me aware of all of this. I didn't
know since I didn't study it. What I know is right now there's Mauna Kea, we supposed to go there to help stop them building another telescope."

**Co-Researcher 2 (understanding the impact of colonization and historical trauma).**

“Well, it may be a good thing (colonization), and on the other hand, maybe not so good. Because, like you know, when we were overthrown, you know that our Queen was overthrown. We had to live by different set of rules. Right? Our lands were taken away, and all of that so, America came in and took over this here. But it comes with a lot of benefits as well too. Sometimes I think it's a pretty good thing. Only sometimes, though. I know what those words mean (historical trauma). My grandmother used to get really upset when we would come home singing Ten Little Indians. I didn't even put two and two together about it. I remember my grandma saying, "I'm going to call up to school and tell them not to teach you guys those songs." Then I remember my dad saying, "why what's wrong with it?" Then she was saying "ten little, nine little, eight little Indians," all the way to what we would do with the last one. They were shooting them and killing them and throwing them in the river to die. And I remember that, so, I know we don't sing that anymore. I tell that story to my kids. I grew up with that song, and you just kind of sing it without even thinking about what it really meant."

**Co-Researcher 3 (understanding the impact of colonization and historical trauma).** “I have not heard of that before.”

**Co-Researcher 4 (understanding the impact of colonization and historical trauma).**

"To me, it means they are trying to change our history. They are trying to erase our ethnic group and trying to erase our past. Trying to stop us from learning the true meaning of what happened and demanding that we learn their ways. So, Mauna Kea. Maybe that I can talk about it, that's historical trauma. It actually started a few years ago, but it actually begin to have an impact this year, and it all has to do it with another telescope. Yeah, although there are telescopes
there already, thirteen of them, they want to build another one, like a bigger one. And like the whole mountain itself is sacred to the people because that's the highest peak in Hawaii. It is closer to the gods. So, every time construction goes on, and a dump truck takes a load of dirt away, they take the bones and ashes of our people because they are buried there and spread all over. When they're taking the dirt away, it's very offensive to men and women that was buried or spread up there, and that is only one of the reasons why. The other reason is because, under that mountain, there's a table of freshwater that's able to last forever. But in order to operate the telescope, they need to drill and use nuclear power. Whatever is happening with the telescope, it heats up and needs cooling off. Yes, so in order to pull it off, they need to drill and use that water. I mean, once it damages the water, nobody on the island will be able to drink it. So, here's a theory, that's actually what the fight is about. A lot of people are asking why are the Hawaiians fighting for the telescope being built now when there's already thirteen telescopes out there.

Well, the answer is there was a lot of politics and going through the hoops with building that many and Hawaiian people never gave consent. There was never a community meeting regarding how the community feels. Nonetheless, in those days, it was back-door policies where the DHL (Department of Hawaiian Homelands) and the University of Hawaii let them set up that kind of deal. Now it's being exposed. So, there's a lot of things for the Hawaiian people like our spirituality. So, we believe the spiritual aspect of what's going on today up there is exposing the lies of what happened. Yes, that's an opening to expose all that to that was done. We Hawaiians weren't that intelligent before, but more Hawaiians are in school learning the Western way than before. Yes, so now we will learn the Western way and use that knowledge to fight them in court. So, yeah, there's a lot of things going on up there. I don't know the full extent. Yes, but because I have gone there, I know there's a lot to the spiritual, and I believe the spiritual will
expose the lies, the crooks, and the dirty politicians. Now we Hawaiians are learning to use their ways against them. Yes. A lot of educated Hawaiians are fighting against these issues now. Before 1959 Hawaii wasn't considered a part of the United States, and it was in 1959 that we became a state. It was a territory before. You know that we Hawaiians were told not to speak our whole language and would will get beaten in school for speaking the Hawaiian language. So, you know talk about historical trauma then; that was another blow to the Hawaiian people too. But what I've learned is colonization is imperialistic views. You take away the language, you take away everything about the Hawaiian history, and then you've got people that are susceptible to accepting whatever Western ways that's brought to them in including alcohol and drugs. Yes, and you know they're teaching us all about American history, whereas you know the truth about it. You know we should actually learn the Hawaiian history, and people should know the truth about what really happened, and I believe in those days that taking away the language was like genocide. So that's pretty much it. I believe what the United States was trying to do was to kill the Hawaiian people, kill the culture. People take away your language first because they disagree with your culture, and then you've got genocide. But, there are a few intelligent Hawaiians that you know learned English and Western ways and know how to fight them with the Western laws. We are learning the truth about what really happened."

**Co-Researcher 5 (understanding the impact of colonization and historical trauma).**

"That's a deep question. Historical trauma is trauma that was done historically to our people. It's happened for generations, and it still happens today. You see it on the news because they always talk about it, like with Mauna Kea and what's going on there now. Also, if you notice when you watch the news every time they talk, it's the same thing, and that's historical trauma about the homeless and drug use. That's historical trauma right there. Talk about mental health issues we have that's historical trauma. It's a cycle, you know."
Co-Researcher 6 (understanding the impact of colonization and historical trauma).

“No. I haven’t heard about that (colonization, historical trauma) either, but it makes sense what you say. Now I would say everything that happened since Captain Cook came can be called historical trauma. If he didn’t come, we wouldn’t have the issues we have today. There would be no alcohol, no meth, no marijuana, no mortgage, no homelessness, no disease. But they say if he didn’t come, somebody else would come and it could be worse.”

Co-Researcher 7 (understanding the impact of colonization and historical trauma).

"Yeah. Well, historical trauma has happened for generations, and it still happens today, like with what's going on with Mauna Kea. They just won't stop taking from us. You would think they had enough."

Co-Researcher 8 (understanding the impact of colonization and historical trauma).

"I've heard those words before (colonization, historical trauma). I've heard a few people use that word before. That's what happened after Captain Cook came to our islands. After he came, then all these other people came, and they started staying in our islands and taking our land and everything else. They started taking away everything, and then they started to live on our islands. They started to change things like I talked about before where they took our lands. Now, most of us struggle here. It's a word (historical trauma) that I hear more now than I used to hear. But what I think it means is that us Hawaiians have suffered a lot over here after all of these other people came. We are coming back, though. We are strong. Like I said before, Hawaii should never have been a state. It should not be part of the United States. Some of us wish that there was a way that we could take it all back. But you know, we can't now, so that's what I think historical trauma means."

Co-Researcher 9 (understanding the impact of colonization and historical trauma).
“Yeah, I heard of that (colonization). That's when other people come and just take over everything. That's what happened to the Native Americans too. Hawaiians have the same problems as Native Americans. So yeah, it's when other people come and take your land away, and then they live on your land and kick you off. We used to use the land and share the land and share our food. Now many other people own our land, and they don't want to share. I'm trying to learn my culture. I know some, but I don't know that much, and I want to take Hawaiian language lessons. Now that's what I'm going to do. I don't think I've heard that word (historical trauma), but I kind of know what it means. It speaks for itself. You know, like Mauna Kea. Right? Mauna Kea is the big issue that we're fighting to save now. On Mauna Kea, they're trying to put up another tower there, and we don't want that. Why do they want to do that? I don't understand. That land is sacred. Hawaiians feel like Hawaii shouldn't belong to the United States. They're up there trying to put that tower up, and they shouldn't be doing that. They don't respect how we feel. I think it's because they don't care about anybody else. So, what I think historical trauma is losing everything, and now they are trying to take Mauna Kea away, but we are protesting, and the whole world knows about it and that we are right about it.”

Co-Researcher 10 (understanding the impact of colonization and historical trauma).

“I think of growing up when you think of colonization but, I never looked at it in a bad way, because we were taught that they came here, and they brought good things. In reality, they don't belong here. Why did they come here and take everything? They take the land, they take the people, they kill the people, and they want front row seats to the ocean. So, colonization, in my definition, is taking what is not theirs and what does not belong to them and doing what they want with it when there's a million people here, and there's 40 of them with guns. We give them our aloha, and they take, take, take, and it's hard because I'm biracial, so I'm always in the middle of that. Now they are taking Mauna Kea, a sacred place to Hawaiians. It's not about the thirteen
telescopes. It's about what we've told them thirteen times before, which is "no" already. How much more do they have to take? How much more? Right? Think of all the explorers we learned about when we were in school. All they talk about is how Pizarro came, and it was all wonderful. You know, I'm sorry, those people were terrible! They were terrible! They gave us alcohol; they gave us diseases, and they take from us. What were we supposed to think? Were we supposed to say thank you and come back and let's trade? So historical trauma is actually very traumatizing to me. It makes me very angry. And learning our culture, it's a work in progress for me to this day, and I try to teach my kids. You know we need to learn and know our culture. Yes, it's kind of late in the game in 2019, and all this happened starting in 1778. So, my thing to my children is, what can we do? We have to preserve. We have to learn. We have to pass down what we can because once there's no more kupunas teaching what was done, and that's when we really die. My people are resilient, and we have survived so much, and we are strong. We've been through so much, and we are still here, but they want us dead because they want our land. That's why we were colonized because the Dole plantation owners wanted our land. So that's my answer."

"I've heard about historical trauma in my anger management classes. Yeah, we really are trying to help people figure out why they act out and what are they angry for. The anger is actually sadness underneath, right? We kill people because we're mad. Ok. I also mean to kill someone because we are sad. That's really why people are killing people, right? So historical trauma is something that we teach to others. Our lands were taken from us. We could not use our language. We could not name our child until 1968 with a Hawaiian name or teach our culture or dance or use our healing practices. The way we gathered food was all taken from us. Why? Why? Because of colonization? Because of historical trauma? I feel angry, but what can we do about it now? Mauna Kea's a perfect example. We have to stand up and fight to protect our sacred mountain. We may lose, but the world knows we are right. Whether you agree with
science or not, then you know what is right. They need to come up with an agreement with the Hawaiian people. You know we already have a thirteen buildings there, so why do they need another big eighteen story building? They want to build it in a beautiful place where there's already thirteen ugly buildings over there. So, when we talk about historical trauma, our people get very upset. To me, it's really understanding what has happened to Indigenous people, and Hawaiians are not the only people that have historical trauma like Mexicans and Native Americans."