Suicide Among Alaska Natives

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Abstract

Scientific evidence is quite strong that the historical trauma perpetrated on Alaska Natives and American Indians has led to the mass adoption of negative coping behaviors which are now transferring trauma intergenerationally from parent to child. Numerous studies have demonstrated that this perpetration of trauma on children leads to their own adoption of many of the same negative coping behaviors as their Elder and parent generations. Recent studies have causally linked numerous negative behaviors to unresolved childhood trauma, including obesity, alcohol abuse, smoking, drug abuse, domestic violence, promiscuity, depression and suicide, among others. Because differing behaviors lead to differing outcomes in the lives of individuals, the linkages among behaviors have not been readily apparent.

As a consequence, advocacy groups have constructed response systems which address single coping mechanisms instead of comprehensive response systems. We have a Suicide Prevention Council, an Advisory Board on Alcoholism and Drug Abuse, The Alaska Tobacco Control Alliance and others. Although this paper speaks about Suicide, the argument made for improving Suicide Prevention efforts advocates for a unifying and more holistic approach involving identification of unresolved historical trauma in the Parent and Elder generations, teaching more appropriate intervention and coping behaviors that lead to a resolution of their own trauma, and teaching them how to avoid the behaviors that inflict trauma on the Child generation.

The model used for explaining Chugachmiut's approach to suicide prevention is referred to as the Restorative Integral Support Model.

Suicide Among Alaska Natives

Don't ever take a fence down until you know why it was put up."
G.K. Chesterton

INTRODUCTION

Chugachmiut, a consortium of 7 sovereign tribes located in Prince William Sound and the lower Kenai Peninsula in Alaska, has been working on developing a Restoration to Health Strategy for our tribal members. Like all Alaska Native communities, we experience very high rates of negative health consequences such as obesity, diabetes, heart disease, cancer and health issues related to alcohol/drug abuse. As we looked for the root cause for the many health problems facing our tribal members, we learned that unresolved childhood trauma (Adverse Childhood Experiences) may actually be that root cause.

While we were initially looking only for a resolution to the health issues our tribal members faced, we became aware that suicide is also linked to unresolved childhood trauma. Because suicide is such a significant problem among Alaska Natives, we chose to examine whether it was appropriate to include suicide within our Restoration to Health Strategy, or to continue to treat it separately.

The most recent figures for suicide in Alaska were presented by the Alaska Department of Health and Social Services in their Epidemiology Bulletin No. 28 dated September 14, 2010. It covers the years 2007-2008. According to the best data available, 233 Alaska Natives committed suicide during that period of time (40.9 per 100,000 population) for a rate that was 2.2 times higher than the comparable rate for Whites in Alaska and 3.5 times higher than the national average (11.5 per 100,000 population). For every successful suicide, 13.5 people (155 per 100,000 population) are seen at emergency rooms for self inflicted injury. This means that approximately 500 additional Alaska Natives may have attempted suicide. Those who think about suicide (ideation) may be about 4.5% of the population (4,500 per 100,000). This figure could be much higher for Alaska Natives, as are actual suicide successes and attempts.

Because of suicide's rather significant impact on tribal life, we came to the conclusion that including it into our Restoration to Health Strategy was a logical fit. Our Restoration to Health Strategy is an initiative to learn about the negative impact of childhood trauma on our health and behaviors in order to seek resolution and healing.

THE ADVERSE CHILDHOOD EXPERIENCE STUDY

The unifying theory for our Restoration to Health Strategy is the Adverse Childhood Experience Study (ACES-1996).[i]

The ACES (1996) examined child development for approximately 17,400 patients of Kaiser Permanente's San Diego Health Appraisal Clinic in a search for clues to a wide range of negative outcomes in adult health and well being, and found some amazing relationships

between negative experiences by children as they are growing and negative behaviors that then led to negative health outcomes.[ii]

8 Adverse childhood experiences were defined and explored with the initial cohort of study participants. This number was increased to 10 for the second cohort. The 10 Adverse Childhood Experience's (ACE's) studied were:

Abuse of Child

- Psychological abuse
- Physical abuse
- Contact sexual abuse

Trauma in Child's Household Environment

- An alcohol and/or drug abuser in the household
- An incarcerated household member
- Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
- Mother is treated violently
- Absent biological parent from the household

Neglect of Child

- Emotional Neglect
- Physical neglect

The results of the study were astounding and informative. The study disclosed that the presence of one or more ACE's are directly linked to higher rates of smoking, alcohol abuse, drug use, suicide attempts, depression, anxiety, promiscuity and sexually transmitted diseases, overeating and toxic relationships. Mind you, not every high ACE's scoring adult exhibits all of these behaviors, but a surprising number do. And cumulative exposure to multiple ACE's directly correspond to increasingly severe negative outcomes.

The study also demonstrated that ACE's are common, and difficult to overcome. At least one ACE was reported by 64% of study participants. [iii] 16% of the population studied reported 4 or more ACE's. One source has estimated the percentage of American Indians with 4 or more ACE's at 33%, [iv] or double that of the total population. The consequences can be dire, as reported in the following article.

Compared with those with an ACE score of zero, people with an ACE score of 4 were:

390 percent more likely to be smokers
390 percent more likely to have chronic pulmonary lung disease
240 percent more likely to have hepatitis
250 percent more likely to have a sexually transmitted disease
460 percent more likely to be suffering from depression
1,220 percent more likely to have attempted suicide.

Those with an ACE score of 6 had a 4,600 percent increase in the likelihood of becoming an IV drug user. Most startling of all: 64 percent of the study participants had experienced one or more categories of adverse childhood experiences.

Targeting obesity at its roots: Adverse childhood experience
By Jane Ellen Stevens
Sacramento Bee, July 31, 2005
http://www.nospank.net/stevens.htm

High ACE scores contribute to the high-risk behaviors discussed above due to the early trauma and its effect on areas of the brain that handle mood, stress response, bonding, memory, and how the body stores fat. In essence, our cells have receptors that prepare us to respond to our environment. Fear, anxiety, stress, love, vitamins, minerals and other requirements for cellular health and response use cellular receptors. Chemicals of emotion are made by the Limbic System, and cascade through the body finding receptors to bond to. If our body processes these chemicals properly, the body returns to normal. If these chemicals, such as fear, are not processed out of the cell, or there are far too many of them being produced, the cell receptor will shrink and die. When the cell divides, the body will make sure that there are more receptors for fear and less for other cellular needs. The Limbic System works on a subconscious or "Implicit Memory" level where we are often unaware of what is happening to us. That's when we seek "Solution's" to the unrelenting feelings we have. This is what can be set up set up during our childhood as unresolved trauma.

The high risk behaviors we adopt in essence become our "solutions" to these chemicals of fear, anxiety and stress, which then contribute to negative health outcomes, one of which is suicide. We smoke, drink, take drugs, overeat, gamble, engage in pornography or promiscuous sex and a multitude of other chemical producing activities that satisfy our cellular need for healing. In an article titled "Obesity: Problem, Solution or Both?," Dr. Vincent Fellitti and his co-authors strongly suggested that our negative eating behaviors in order to maintain a large weight may actually be considered a solution by patients. The negative behavior is an attempt to try feeling better, and is rooted in this neurobiology of the brain. But as Dr. Fellitti stated in this paper, "It's hard to get enough of something that almost works." The patient solutions are partially effective for a short time, but do not lead to long lasting complete resolution of the problems.

It is likely that patients progress to attempting a series of negative behavioral solutions because the first behavior adopted does not provide the sought after total solution. Each successive solution tries building upon the previously attempted solution. For example, a child experiencing multiple ACE's may very well start seeking their solutions by first using food to satisfy their needs, then start to smoke, might progress to bullying, and then to drug use or drinking. Attention seeking behaviors, including promiscuity, may be another behavior used by children. The final solution sought might be suicide. In any event, it may be helpful to keep this progression of attempted solutions in mind as we start to look at how we can seek true prevention for some the unintended consequences of these .

The area of concern for this paper is, of course, suicide. Alaska Natives experience suicide at rates 2 to 4 times the statewide average, depending on the region of Alaska reporting. While no age grouping is exempt from suicide, the age groups from 15 to 24 and 85+ have the highest rates. Alaska Native men commit suicide more often than women by 3-1.

SUICIDE'S ROOT CAUSE

This analysis relies on the framework set out on Attachment A-the "Restorative Integral Support Model." (RISM) [v] RISM proposes 4 quadrants that represent the "interior" for a human, the "exterior," the values system and social systems. The root cause for suicide behavior develops in quadrant "I" or the interior human. This is where the inner child experiences and reacts neurobiologically to trauma. Suicide, as a behavior, shows up in quadrant "IT."

While suicide has a huge psychological and economic impact on our small Alaska Native communities and its families, we want to state that we should always recognize that a majority of our tribal members do not contemplate suicide (ideate, plan or attempt suicide-" suicide behaviors") as an option in their lives. And while a significant number attempt suicide, only a small percentage of that number are successful. This may mean that this small group actually seeks help before they formulate or put a plan into action. One of our goal should be to reach this group and provide them that help. This function is displayed in quadrant "ITS."

Traditional notions for the derivation of suicide behaviors are similar to this quote from The Centre for Suicide Prevention in Calgary, Canada, in its 2003 study titled Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies:

> "We know that there are a wide range of general risk factors that have been shown to contribute to suicide in all adolescents, regardless of their cultural background. Examples of such risk factors include: depression, alcohol and substance abuse, a family history of suicide, social isolation, and access to firearms. However, in the case of Aboriginal young people, we can argue that they face, on average, a greater number of these risk factors at one or that the risk factors are more severe in nature.

In the RISM, the risk factors for suicide, as presented, are expressed in Quadrant IT, and reflect the behavioral response for trauma encountered in Quadrant I. Depression, alcohol use, substance abuse and other "risk factors" may actually be the "solutions" referred to by Dr. Fellitti, as Quadrant IT behaviors.

Surgeon General Dr. Richard H. Carmona reflected similar knowledge when he presented the following testimony before the U.S. Senate Committee on Indian Affairs in June of 2005: "Suicide is not a single problem; rather it is a single response to multiple problems." [vi] He said further in support of this statement:

> The reality is that we have not adequately explored either the problems or the necessary responses. We know that some of the underlying social, educational, and cultural issues related to suicide include poverty, lack of economic opportunity, limited educational alternatives, community breakdown, familial disruption, and stigma; and we need to better understand the role of social risk and protective factors. These social issues are every bit as important to understand and address as are clinical factors such as substance abuse and mental health. We know that these factors are all critical to promoting long-term health and minimizing potential suicidal behavior. We can guide and evaluate programs to reduce suicidal behavior by what we learn about social, educational, cultural, and clinical factors.

Dr. Carmona's identification of social issues meshes well with the cultural framework of Quadrant WE. Young aboriginal people face a greater number of "risk factors" because of a lack of knowledge about what our response should be. We focus on Quadrant IT issues as the problem. We try to respond to the "problem" by adopting laws, establishing policies and surveillance and monitoring systems, which are Quadrant ITS response. We choose cultural restoration projects that may be inappropriate as Quadrant WE responses that cannot overcome Quadrant I issues in any meaningful way.

The RISM model leads to our belief that suicide behaviors are a response to the root cause of unresolved childhood trauma (ACE's) just like substance abuse, depression and the many other negative outcomes are responses to ACE's. Let's look at the evidence.

With respect to causation for suicide behaviors, the results found in the ACES are astonishing. The ACES established a strong graded correlation between lifetime suicide attempts and the number of Adverse Childhood Experiences. [vii] The graph in the endnotes of the study demonstrate the relationships: 8.5% attempted suicide with 4 ACE's; 13.8% attempted with 5 ACEs; 21.8% attempted with 6 ACEs; and 35.2% attempted with 7 ACEs. It is estimated that approximately 16.4% of the general U.S. population have 4 or more ACEs. American Indians, in the one reference I found referring to ACE's, indicated that 33% had 4 or more ACEs. If the numbers are accurate, then the higher rate of suicide attempts by Alaska Natives can be explained by their higher proportion of ACE's.

We do recognize that ACE's do not explain all of the suicide behaviors. Dube et al. (2001) calculated ACE attributable risk factors for suicide as: "The estimated ARFs (Attributable Risk Fractions) for lifetime, childhood/adolescent, and adult suicide attempts were 67%, 80%, and 64%, respectively." (p. 3094) This means that 2/3rds or more of suicide attempts are most likely attributable to the impact of ACEs. We must continue to seek the additional ARF's for suicide. Gary Weglarz, a behavioral health clinician at the Southeast Alaska Regional Health Corporation (SEARHC) in Juneau, Alaska, has supplemented the original ACE's survey to include identification of boarding school inflicted trauma. [viii] Boarding schools were common experiences among our current Elder and parent generations. Boarding school experience may well be an additional contributor to the rate of suicide among Alaska Natives and American Indians.

Still, identifying this small group requires a means for identifying them. This is where the ACE Study questionnaire might help. (Attachment B) The questionnaire probes an individual's recollection of negative experiences encountered in childhood. One problem with such a self administered questionnaire is a lack of recollection. Trauma survivors often have no recollection for different reasons. Often times, the trauma is not observed by the conscious brain and is only recorded indirectly through brain and body response. In other cases, the brain is substantially traumatized and chooses to forget, or dissociate, the memory. Sometimes we choose not to remember because of the societal implications of the traumatizing behavior, or the unimaginable perpetrator of the trauma. If memory allows a trauma victim to recall their trauma, the ACE questionnaire can provide clues for what shows up in Quadrant IT.

DEVELOPING A TRUE PREVENTION STRATEGY

Quadrants I and IT model how the inner and exterior selves develop trauma and lead to adoption of negative behaviors as "solutions" or coping mechanisms. Two solutions present themselves. The first is to stop trauma from developing. The second is to resolve the trauma after it presents.

A true suicide prevention strategy must be rooted in a single minded focus on preventing our children's generation from exposure to Adverse Childhood Experiences and development of trauma. This requires a substantial effort to help our Elder and parent generation heal, or working in Quadrant IT, to mitigate the behaviors that perpetuate the transmission of intergenerational trauma.

One logical place for this work to start is with the Alaska Tribal Health System's primary care practice. Dr. Felitti argues that the Physician's office is the logical place to start for addressing unresolved trauma due to the potential for substantial improvements for a variety of health care problems encountered by patients with unresolved trauma. Felitti analogizes our treatment for chronic diseases as similar to the relationship of fire to smoke:

> Our usual approach to many adult chronic diseases reminds one of the relationship of smoke to fire. For a person unfamiliar with fires, it would initially be tempting to treat the smoke because that is the most visible aspect of the problem. Fortunately, fire departments learned long ago to distinguish cause from effect; else, they would carry fans rather than water hoses to their work. What we have learned in the ACE Study represents the underlying fire in medical practice where we often treat symptoms rather than underlying causes. [ix]

A primary care practice can start to incorporate new practice dynamics by recognizing unresolved childhood trauma through asking about the patient's exposure in relationship to the symptoms experienced. Here is Dr. Felitti's discussion on a consultation he had about a patient in his system.

> If the treatment implications of what we found in the ACE Study are far-reaching, the prevention aspects are positively daunting. The very nature of the material is

such as to make one uncomfortable. Why would one want to leave the relative comfort of traditional organic disease and enter this area of threatening uncertainty that none of us has been trained to deal with? And yet, literally as I am writing these words, I am interrupted to consult on a 70-year- old woman who is diabetic and hypertensive. The initial description given to me left out the fact that she is morbidly obese (one doesn't go out of one's way to identify what one can't handle). Review of her chart shows her to be chronically depressed, never married, and, because we routinely ask the question of 58,000 adults a year, to have been raped by her older brother six decades ago when she was ten. That brother molested her sister who is said also to be leading a troubled life.

We found that 22% of our Kaiser members were sexually abused as children. How does that affect a person later in life? How does it show up in the doctor's office? What does it mean that sexual abuse is never spoken of? Most of us initially are uncomfortable about obtaining or using such information; therefore we find it useful routinely to pose such questions to all patients by questionnaire. Our Yes response rates are quite high as the ACE Study indicates. We then ask patients acknowledging such experience, "*How did that affect you later in life*?" This question is easy to ask and is neither judgmental nor threatening to hear. It works well and you should remember to use it. It typically provides profoundly important information, and does so concisely. It often gives one a clear idea where to go with treatment.

What then is this woman's diagnosis? Is she just another hypertensive, diabetic old woman or is there more to the practice of medicine? Here is the way we conceptualized her problems:

Childhood sexual abuse
Chronic depression
Morbid obesity
Diabetes mellitus
Hypertension
Hyperlipidemia
Coronary artery disease
Macular degeneration
Psoriasis

This is not a comfortable diagnostic formulation because it points out that our attention is typically focused on tertiary consequences, far downstream. It reveals that the primary issues are well protected by social convention and taboo. It points out that we physicians have limited ourselves to the smallest part of the problem, that part where we are comfortable as mere prescribers of medication. Which diagnostic choice shall we make? Who shall make it? And, if not now, when?

If we start by addressing health issues in the primary care office when they are observed by looking back into Quadrant I issues, we should be able to help resolve Quadrant IT

behavioral issues before they become the serious health issues seen in the patient description above.

If we are able to help the parent generation heal their childhood traumas, we improve our ability to help the children's generation to avoid trauma. And if we extend our surveillance system, we can help that generation resolve their trauma at an early age, before negative behaviors start to occur.

Teaching the healed Elder and parent generations proper parenting will minimize the perpetration of trauma on their children. Trauma informed therapy, appropriate child welfare intervention and the broader surveillance strategies need to be discussed and emphasized on a community wide basis for the children of nonparticipating Elders and parents. This strategy is proper for introduction in Quadrant WE. Many of the cultural based suicide intervention strategies teach awareness, coping skills and intervention techniques. However, we don't believe they are suitable for resolving childhood trauma. The may build resilience, but in most cases, the unresolved trauma will seek other solutions for soothing or comforting. Still, improving shared values and world view is necessary for a severely damaged culture such as ours.

With respect to suicide intervention and treatment, the existing surveillance system development needs to continue in effect. As we implement a Restoration to Health Strategy, and find pathways to success, we should start to see a decrease in the adoption of risky behaviors, and an improvement in overall health statistics, including a decrease in suicide ideation and attempts.

While resolving childhood trauma is the most critical part of our strategy, we have identified some positive steps in order to prepare our tribal members for resolving that trauma.

The health of our brain is important, and requires good nutrition, proper hydration, exercise, and sometimes supplementation, to support a proper Therapeutical response to treatment.

Behavioral health services are essential to meeting this reduction in negative behaviors, including suicide behaviors. The availability of trauma informed services, and the elimination of stigma attached to behavioral health services is essential. For severely traumatized adults, including those who have been incarcerated for a significant period of time, substantial services for employability and personal development are likely to be necessary. Substance abuse services to break the cycle of addiction are also necessary. Fortunately, this type of service is already included in all of the suicide prevention plans formulated for participation by Alaska Natives. Funding such services is, however, not available in the quantity or quality necessary.

Part of Chugachmiut's plan for implementing its Restoration to Health Strategy was the convening of a regional "consultation" of tribal leaders, patients, clients and citizens to discuss the impact of historical and intergenerational trauma on our Villages, and arrive at

an understanding on how to formulate a regional response (Quadrant WE activity). How, for example, shall we educate our tribal members about the negative impact of ACE's without implicating and blaming the Parent and Elder generations. After all, they suffered from the same trauma as many in the current Children's generation are suffering. And how will our cultural values be recognized and supported during implementation of the strategy? Can we develop a blame and shame free environment while implementing the strategy? Can we learn how to forgive those that have abused us in the past, and can we effectively learn to acknowledge and apologize for our past bad behaviors? Can the Village leadership develop wholesome activities to replace the alcohol and drug abuse that does exist? These are among many of the questions that have to be addressed in order to implement an effective Village based strategy.

Successful programs for helping children who experience childhood trauma is also critical to successfully preventing suicides. This is especially true for children with parents who have not healed. Children are remarkably resilient if provided assistance when the trauma occurs. The difficulty is in determining whether and when trauma has actually occurred. Some ACE traumas are easy to observe. Excessive alcohol abuse, already diagnosed depression, an absent biological parent or an incarcerated parent may be easy to observe in a small Village. The abusive behaviors are not always easy to determine due to the strong incentive for denial. Physical and emotional abuse, physical and emotional neglect, sexual abuse and domestic violence are often hidden.

Once trauma is identified, there are a variety of interventions that work. The problem in Village Alaska is that the interventions are most likely not available. According to a 2004 review of the availability of mental health services in rural Alaska, virtually the entire state is a mental health professional shortage area. [x] The ratio of providers to population is quite low. Even more problematic is the wide distribution of the rural population, and the lack of providers to travel to where the services are needed.

CONCLUSION

Historical Trauma and Intergeneration Transfer of that trauma to succeeding generations (RISM Quadrant I) have led to adoption of negative coping behaviors (RISM Quadrant IT) that damage many Alaska Natives physically and mentally. Substance abuse, smoking, depression, suicide behaviors, anger and violence, promiscuity and other coping mechanisms severely damage people and their relationships (Quadrant WE). ACES provides a unifying theory for why individuals adopt negative coping behaviors. As the root cause for negative behaviors, it becomes clear that preventing the Intergenerational Transfer of Trauma is a key to reducing suicide, as well as a host of other negative outcomes for Alaska Natives. As Dr. Carmona stated, suicide is only one expression for the multiple problems that exist.

In our opinion, intervening will require a shift in our collective mindset. We first need to acknowledge the substantial impact that ACE's have in our lives. While we are children, and unable to fully understand that impact, our responsibility and accountability for dealing with the impact of trauma needs to be absorbed by our parent generation and the

community. For our Parent generation, they will need to become responsible for their behaviors, and accountable for their actions, but the community needs to create an environment where responsibility and accountability don't initially lead to stigma, blame, shame or punishment. If this environment can be developed, then the Parent generation can work on resolving their trauma, and developing the skills to live a happy and productive life.

As the Parent generation becomes more accountable, they will need to learn appropriate behaviors and how to parent effectively. Learning how to sustain relationships, and intimate relationships in particular, will become a critical skill to learn.

As we gradually and collectively achieve healing, not only should suicide behaviors diminish, but so should a substantial number of negative behavioral and health outcomes for Alaska Natives. Chronic health conditions should diminish as the negative behaviors that support them resolve. Reduced smoking, alcohol and drug abuse, less incidents of domestic and other violence—a whole litany of problems should start to resolve through resolving our childhood traumas, and preventing their transmission to succeeding generations. The savings to the Alaska Native Tribal Health System should accrue rapidly, and the ability of those who are healed to live happier lives increase exponentially. This will eventually lead to a smaller investment in treatment programs, police and jails, and a reduction in productivity cause by negative coping behaviors.

There are many aspects of this proposal to discuss that haven't been touched on. First, we need to come to agreement about whether the approach proposed has the potential for success. Chugachmiut and its tribes have already affirmatively made this decision. We are proceeding with implementation. We share this in the hope that other tribes see merit in our work and choose to move forward.

ENDNOTES

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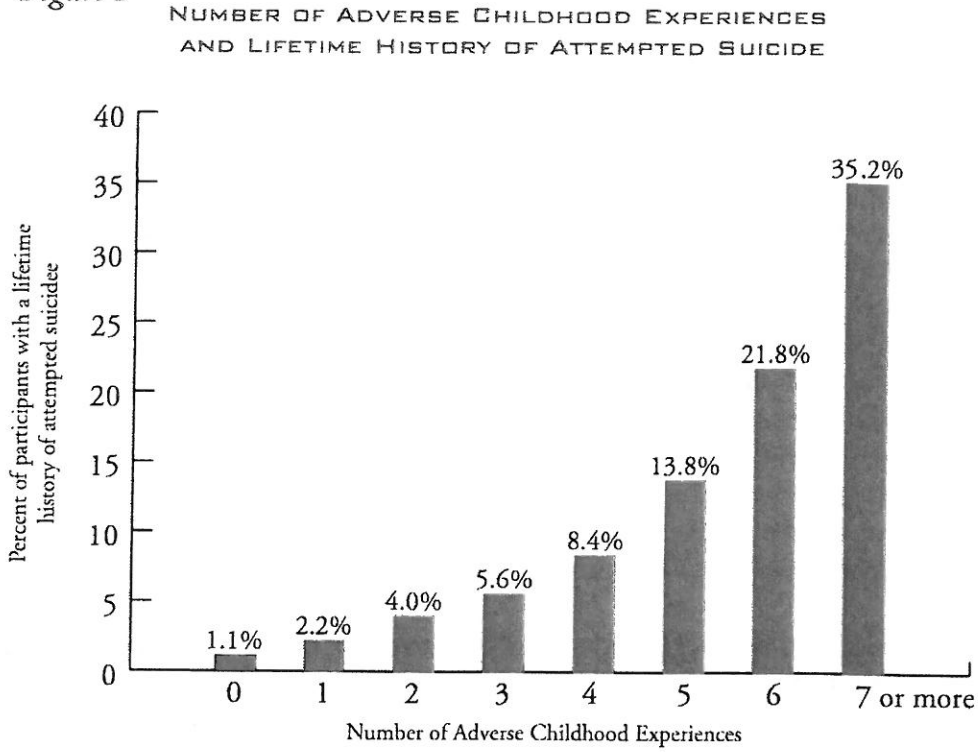
[i] Fellitti, et al, "The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction," *American Journal of Preventive Medicine* (1998) Volume 14, pages 245–258.
[ii] Dube, et al, "Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings From the Adverse Childhood Experiences Study," Journal of the American Medical Association, December 26, 2001—Vol 286, No. 24, pp. 3089-3096
[iii] Anda, et al. "The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology." Eur Arch Psychiatry Clin Neurosci (2006) 256 : 174–186
[iv] Koss et al., Adverse Childhood Exposures and Alcohol Dependence Among Seven Native American Tribes, Am J Prev Med 2003;25 (3):238-244
[v] Larkin, H.; Records, J. (2007). Adverse Childhood Experiences: Overview, response strategy, and Integral theory. *AQAL: The Journal of Integral Theory and Practice, 2(3), 1-25.*
[vi] Testimony Before the Indian Affairs Committee United States Senate
Suicide Prevention Among Native American Youth
Statement of Richard H. Carmona, M.D., M.P.H., F.A.C.S.

Surgeon General U.S. Public Health Service Office of Public Health and Science U.S. Department of Health and Human Services
Wednesday, June 15, 2005

Figure 1[10]



vii

viii Personal email communication to Patrick Anderson dated April 14, 2011.

ix Felitti VJ. The relationship between adverse childhood experiences and adult health: turning gold into lead. *The Permanente Journal* 2002;6:44–47

x Western Interstate Commission for Higher Education (WICHE) Mental Health Program "The Behavioral Health Workforce in Alaska: A Status Report" March 2004

Restorative Integral Support Model

Levels and Lines of development Emotion, thoughts, And interior experiences	Behaviors Physical organism Physical health
Individual: self and development model Adverse Childhood Experiences	What shows up: negative behaviors (coping strategies) and exterior problems (health impacts)
I	IT
WE	ITS
Group values pertaining to: Family Community Sub-culture Larger culture	Physical trauma, neglect and abuse Family Relational system Rules, guidelines, regulations, Policies, laws, systems School System Health-care system Legal or other systems
Shared Values and World Views	Social Systems and response

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.