The Framework of Historical Oppression, Resilience and Transcendence to Understand Disparities in Depression Amongst Indigenous Peoples

Catherine E. Burnette ^{1,*}, Lynette M. Renner² and Charles R. Figley¹

¹*School of Social Work, Tulane University, 127 Elk Place, New Orleans, LA 70112, USA*

²*School of Social Work, University of Minnesota, 105 Peters Hall, 1404 Gortner Avenue, St. Paul, MN 55108, USA*

*Correspondence to Catherine E. Burnette, School of Social Work, Tulane University, 127 Elk Place, New Orleans, LA 70112, USA. E-mail: cburnet3@tulane.edu

Abstract

Given chronic experiences of historical oppression, Indigenous peoples tend to experience much higher rates of depression than the general US population, which then, drives disproportionately high rates of suicide and other health disparities. The purpose of this research was to examine the core components of the culturally grounded Framework of Historical Oppression, Resilience, and Transcendence as they relate to depressive symptoms experienced by Indigenous peoples. As part of a larger convergent mixed-methods study, in this quantitative survey component, we utilised data from a sample of 127 Indigenous adults across two Southeastern US tribes. Regression analysis results signified support for the framework, indicating that historical oppression and proximal stress (daily stressors and lower incomes) were risk factors, whereas family resilience and life satisfaction (a measure of transcendence) were protective factors related to depressive symptoms. The results provide a foundation for future research to build upon in identifying culturally relevant risk and protective factors to ameliorate depression and other health disparities.

Keywords: depression, health disparities, historical oppression and trauma, Indigenous/ Native American/American Indian, resilience

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Introduction

Despite the more than five centuries of inequities waged against Indigenous peoples since European American colonisation first began, a lack of organising and culturally relevant frameworks are available to explain or address such disparities (Jones, 2006). The Framework of Historical Oppression, Resilience, and Transcendence (FHORT) fills this gap in culturally relevant, strengths-based and holistic frameworks, which are needed for social workers to understand, explain and prevent these disparities. Indeed, disparities in depression and other social and health outcomes can overshadow the remarkable resilience and transcendence of Indigenous peoples, precluding the ability to identify strengths and promotive factors (Barney, 2001). This over-focus on problems can perpetuate the marginalisation of already oppressed groups and make invisible the profound strengths of Indigenous families and communities, which have sustained and enabled survival for centuries. The FHORT is an empirically based and culturally grounded conceptual approach, developed with Indigenous communities; it addresses social, behavioural, physical and psychological health disparities and has been used to explain and understand the disproportionate levels of violence experienced by Indigenous peoples (Burnette and Figley, 2017). In addition to disparities, it places equal attention to the immense successes and transcendence continuously demonstrated by such populations (Burnette and Figley, 2017).

Regarding disparities, the Treaty Agreements between the USA and its 573 federal sovereign tribes (Bureau of Indian Affairs, 2019) require the government to provide for the health and well-being of Indigenous peoples (U.S. Commission on Civil Rights, 2004). We limit the scope of this research to Indigenous peoples of the contiguous USA (the connected forty-eight states, not including Hawaii and Alaska). Mentions of Indigenous peoples are referent to this region. 'Indigenous peoples' is a term used by international organisations to describe geographically and culturally distinct groups with diverse histories, albeit who share a common history of experiences and oppression as a result of European colonisation (Gray et al., 2013). Although this article focuses on Indigenous peoples of the contiguous USA, the term 'Indigenous' is used to acknowledge this shared history of colonisation and its effects.

However, because of a context of chronic historical oppression, Indigenous peoples tend to experience some of the most severe health disparities in comparison with other races (U.S. Commission on Civil Rights, 2004). The concept of 'historical oppression' captures the chronic, pervasive and intergenerational experiences of oppression that Indigenous peoples were exposed to throughout colonisation and into the present, which, over time, may be normalised, imposed and

internalised into peoples' daily lives (including individuals, families and communities) (Burnette and Figley, 2017). With respect to mental health disparities, Indigenous populations have been found to experience serious psychological distress at 1.5 times the rate of the general population (American Psychological Association, 2010), and elevated levels of depression, substance abuse and dependence, post-traumatic stress disorder and suicide (American Psychological Association, 2010; Gone and Trimble, 2012; Sarche and Spicer, 2008).

These health inequities not only indicate a failure of the US federal government but also are of grave concern and salient priorities across the globe. Internationally, the Sustainable Development Goals are a set of seventeen global goals put forth by the United Nations (UN) and are considered a path to achieve a more sustainable future for all by the year 2030 (United Nations, 2018). These goals address challenges related to inequality, poverty, environmental injustice, peace, climate change and justice. For the first time in 2015, the Sustainable Development Agenda officially recognised the importance of mental health and well-being, with the prevention of substance abuse included as one of these components (World Health Organization, 2018). Specifically, the title of one of the seventeen goals is 'Good health and Well-being' (United Nations, 2018), highlighting the need to address inequities in social, psychological, health and well-being.

Purpose of this research

Across the general adult US population, 6.7 per cent experienced a major depressive episode in 2015. For Indigenous peoples, however, the rate was much higher at 8.9 per cent—higher than all other ethnicities except those with multiple ethnic identities (The National Institute of Mental Health, 2015). Likewise, other researchers indicated that in the years 2005–2006, 5.4 per cent of Americans who are in the age group of twelve years and above experienced depression, as measured by the Patient Health Questionnaire (PHQ-9) (Pratt and Brody, 2008). Yet, Indigenous peoples are 1.7 times more likely to experience suicide than the general US population (Indian Health Service, 2018). Suicide prevention efforts must focus on correlates of mental health symptoms, such as depressive symptoms. Moreover, depressive symptoms are linked to a multitude of physical health problems, such as diabetes, cardiovascular disease and hypertension, which are in themselves risk factors for many additional health problems (Cooper *et al.*, 2014). As such, the scope of this study is limited to risk and protective factors related to depressive symptoms. Risk and protective factors are related to an additional focus of this manuscript, 'resilience'—bouncing back and recovering well after experiencing adversity, and 'transcendence'—a

higher level of functioning, akin to post-traumatic growth (Tedeschi and Calhoun, 2004), which is the experience of positive change (i.e. increased gratitude, improved personal relationships, sense of personal strength, changing priorities, enriched meaning and spirituality) that occurs as a result of a struggle with challenging life circumstances.

Prior researchers have linked historical oppression and trauma throughout colonisation to Indigenous social and health disparities and inequalities in broad ways (Gone and Trimble, 2012). Until recently, however, there has been a dearth of comprehensive frameworks and use of decolonising research to explain such disparities in a culturally relevant way (Burnette and Figley, 2017). The purpose of this research is to build upon the synthesis of the research that informed the FHORT as it relates to violence (Burnette and Figley, 2017) by examining its core components as they relate to depression experienced by Indigenous peoples. We focused on the health disparity of depression, which drives suicide and heightened mortality experienced by Indigenous peoples (Indian Health Service, 2018). Specifically, we examined the concepts of historical oppression (including the heightened proximal stressors), resilience (family resilience) and transcendence (life satisfaction) to understand and explain depressive symptoms amongst the study participants. Knowledge gained from this inquiry may inform social workers' prevention and treatment for the major health inequity of depression. A strength is in the focus, not only on symptoms of depression, but also on underlying causes, such as historical oppression.

The FHORT

Historical oppression expands upon historical trauma, a concept that encompasses the massive and chronic trauma imposed on a group (Brave Heart, 1999a,b; Brave Heart and DeBruyn, 1998). For the tribes in this study, some forms of historical trauma experienced include land dispossession, the loss of lives through warfare and disease, forced removal and relocation, the assimilative and oftentimes abusive boarding schools, laws prohibiting Indigenous religious practices and environmental injustices (Evans-Campbell, 2008; Harper and Entrekin, 2006). Unlike historical trauma, historical oppression focuses on 'both' historical 'and' contemporary forms of oppression (i.e. proximal stressors), which tend to perpetuate oppression, such as higher levels of stress, lower incomes and health disparities.

The roots of this framework draw from the work of Freire (2000). Examples of historical losses resultant from colonial oppression include but are not limited to loss of land, traditions/spiritual practices, language, family ties and trust following broken treaties, in addition to experiencing alcoholism, social problems and premature deaths

(Whitbeck *et al.*, 2004). These losses may contribute to people's feelings of depression and resignation, in addition to high rates of health and mental health disparities such as depression, suicide, violence, post-traumatic stress disorder and substance abuse (Brave Heart, 1999a,b; Brave Heart and DeBruyn, 1998). People who have been systematically marginalised may feel ineffectual to change the systems of power. They may inadvertently adopt the oppressor's dehumanising beliefs and behaviours (i.e. internalised oppression). They may find themselves striking out at those of equal or less power (e.g. women, children) through horizontal violence and sub-oppression (Freire, 2000). The higher levels of daily stress and poverty (Gone and Trimble, 2012) experienced by Indigenous people exacerbates and perpetuates cumulative oppression and may erode the prosocial values of unity, social action, co-operation and the capacity to transcend oppression (Burnette and Figley, 2017).

According to the FHORT, it is the interaction, accumulation, interconnections and balance of risk (i.e. factors that exacerbate problems) and protective (i.e. factors that buffer negative outcomes or promote positive outcomes) factors across multiple levels (e.g. individual, family/relational, community/cultural, societal) that explain whether a person experiences wellness (balance amongst the mind, body, spirit and relations with others and the environment) after experiencing adversity. This perspective is congruent with Indigenous peoples' holistic and relational view of the interconnections between physical, mental, emotional, social, environmental and spiritual health (Cross, 1998; West *et al.*, 2012).

Regarding resilience—individuals, relationships, families, communities and societies—have protective qualities, making resilience applicable across multiple levels (Masten, 2018). Although early researchers conceptualised resilience as a static individual trait or characteristic, more recent researchers highlight the salience of culturally relevant and localised of protective, promotive and risk factors that enhance processes of resilience across ecological levels (Ungar and Liebenberg, 2011; Walsh, 2013). Promotive factors are family resources and positive characteristics, which help across all levels of risk (Masten, 2018). Scholars have noted the salience of family resilience in collectivist and family-oriented cultures (Chang *et al.*, 2015; Faqurudheen *et al.*, 2014; Theron *et al.*, 2011; Theron and Theron, 2013; Ungar, 2010). People may not only respond to adversity but they may transcend it, as evidenced through greater life satisfaction and quality of life. Life satisfaction has been shown to be negatively associated with depression in other studies, though this finding has not been investigated with Indigenous populations (Koivumaa-Honkanen *et al.*, 2004).

Family is an especially important cornerstone for ethnic minority families who may feel pushed to the margins, in contrast to the privileges afforded to European American families. Minority families may be more

likely to receive poorer or inconsistent care—or lack access to care through formal service systems altogether (e.g. therapeutic, social services, school-based services) (Burnette, 2015, 2018). Nowhere is this likely more true than within Indigenous populations of the USA, for whom family makes up the majority of social support and acts as a conduit for culture transmission (Burnette, 2018; Carlton *et al.*, 2006; Kirmayer *et al.*, 2011; McCubbin and McCubbin, 2013; Stiffman *et al.*, 2007; Weaver and White, 1997).

Risk and protective factors related to depression amongst Indigenous peoples

Despite depression being prominent amongst Indigenous adult Americans, research on the problem is scarce (Roh *et al.*, 2015b). The available research tends to focus on depression and/or suicide experienced by Indigenous youth samples (Burnette and Figley, 2016) and the scope of this article is limited to adults. Researchers have found social support to be a protective factor for depression amongst older Indigenous adults, and this support largely comes from family members (Roh *et al.*, 2015a,b). Whitbeck and colleagues examined depression amongst 287 Indigenous adults and found that perceived discrimination was a risk factor, whereas engagement with traditional practices was protective (Whitbeck *et al.*, 2002).

The few aforementioned empirical research studies on depression amongst Indigenous people emphasised the relevance of historical oppression to depression; yet, to our knowledge, did not measure historical oppression as it relates to depressive symptoms. With the exception of Whitbeck *et al.*'s (2002) inclusion of discrimination, proximal stress (i.e. daily stressors) were not measured, nor was resilience. This research makes clear that social support is a protective factor, with families tending to make up the majority of social support in Indigenous communities (Dalla *et al.*, 2010). A systematic review related to Indigenous youth's mental health disparities indicated that the greatest number of risk and protective factors occurred at family (41 per cent) and relational levels (59 per cent) (vs. individual or community levels (Burnette and Figley, 2016)).

Gaps in research

To our knowledge, no researchers have examined Indigenous family resilience as it relates to depression, individual wellness or life satisfaction. Thus, our study provides important foundational research examining the interrelationships between historical oppression, resilience and

Figure 1: Conceptual framework for this study, based on the FHORT. The direction of each hypotheses are denoted by either + or – sign, for a positive and negative relationship with depressive symptoms, respectively

depression. The FHORT has forged this connection empirically using qualitative data and the current study goes further to examine it through quantitative survey data. We measured the key concepts of the framework (see Figure 1), namely how the risk factors of (i) perceived historical oppression (including measures of internalised oppression, sub-oppression, resignation, horizontal violence, marginalisation), (ii) proximal stressors that perpetuate oppression (i.e. daily hassles and lower income) and the protective factors of (iii) resilience (i.e. family resilience) and individual transcendence (i.e. satisfaction with life) may impact depression.

Based on the FHORT, we expected that:

- Hypothesis 1:* Perceived historical oppression would be positively associated with depressive symptoms.
- Hypothesis 2:* Proximal stressors (a component of historical oppression) would be associated with levels of depression. Specifically, we expected that daily stress would be positively associated with depressive symptoms and income would be negatively associated with depressive symptoms.
- Hypothesis 3:* Family resilience would be negatively associated with depressive symptoms.
- Hypothesis 4:* Life satisfaction (a measure of transcendence) would be negatively associated with depressive symptoms.

Method

Study design

The current study was part of a larger convergent mixed-methods study, which merged findings from both quantitative and qualitative data

(Creswell, 2015). This decolonising research approach prioritised the voices of participants through culturally congruent, storytelling methodologies as part of a critical ethnography informed by Freire (2000) and Smith (2008). According to Smith (2008), decolonising methodologies create space for Indigenous knowledge and take a critical view of power relations of inequities, seeking to transform oppression for the empowerment of Indigenous peoples. Consistent with the FHORT, the methodology of this study followed guidelines for ethical and culturally relevant research, incorporating the decolonising strategies of using culturally congruent and relational methods, engaging in long-term transformative research, reinforcing strengths, hiring and including tribal partners throughout the collaborative process, reciprocal relationships and building research infrastructure, amongst others (Burnette et al., 2014).

For example, for the qualitative portion of the study, we took a life history approach and tribal members were compensated for their time and received a copy of this important history if they wanted it. We thus, prioritised participant's stories in their own voices (Denzin et al., 2008), which has been retained in the qualitative results and has directly informed the culturally grounded measures used for this article. Additionally, tribal members were hired as research assistants and were involved in data collection, analysis and dissemination. Results were reported to the tribal communities on over ten occasions through presentations, community dialogue groups and workshops. Finally, this work is informing community-based participatory research (CBPR) to create a culturally relevant intervention addressing the identified needs.

The current study activities were approved through the respective tribal councils and University Institutional Review Board (IRB), and all participants provided verbal or written consent prior to the start of research activities. Ethnographic research, with data from 1,058 participants across two tribes, consisted of field notes, existing data, individual and focus group interviews with elders, adults, professionals and youth, as well as whole family interviews focused on identifying culturally relevant risk and protective factors across ecological levels (Burnette et al., 2017). These qualitative results directly informed the quantitative follow-up survey, which is the focus of this research study. Where possible, we included existing validated measures for each overarching theme that had been used with Indigenous populations. When existing measures were not available or suitable for the population, the lead author created scales to assess the core concepts (e.g. The Historical Oppression Scale and the Family Resilience Inventory). To develop scales, we created items to measure each of the overarching qualitative

themes related to the construct of inquiry (e.g. family resilience). Extensive discussion of the development of these scales may be found elsewhere (Burnette *et al.*, 2018; 2019).

Sample

The survey sample included members from the two tribes involved in the qualitative research. Both tribes were located in the southeastern region of the USA, with populations greater than 10,000 members each. The details of the tribes and their names are not included in order to protect tribal identity. Tribe A is a federally recognised tribe located further inland from the Gulf of Mexico and has had economic growth and development. It operates tribal schools, health and behavioural health services, criminal justice, law enforcement, emergency and land based services and family and social services. Tribe B is a state tribe but not federally recognised. It is located on or near the Gulf Coast. Tribe B is afforded less economic and tribally specific services, with absence of federal recognition, which undermines the growth of the needed tribal infrastructure. Tribe B provides educational, employment, domestic violence and youth and elderly services and programmes. Both tribes experienced significant and chronic historical oppression, which is connected to the history of ethnic and race relations in the Jim Crow Deep South, where tribal members experienced educational discrimination and economic oppression. Indigenous members of these regions tended to find sustenance as sharecroppers, living off the river and coastal environments of the Gulf South, with almost no opportunity for upwards economic mobility until on or after the 1970s.

After tribal and University IRB approval, participants of the qualitative portion of the study were invited to participate in the online follow-up survey, delivered through Qualtrics software (Qualtrics, 2014). Participants were entered into a drawing for \$50 gift cards and over half of the participants ($n = 70$, 55 per cent) received a gift card. Participants' names were kept separately from survey data and utilised only for the purpose of participant compensation. Initially, 161 participants started the survey with 79 per cent completing ($N = 127$). The final sample consisted of 127 adult respondents ($n = 104$ females, $n = 23$ males) from the two tribes ($n = 80$ from Tribe A and $n = 47$ from Tribe B). The respondents' ages ranged from twenty-one to eighty years, with a mean of 46.20 years ($SD = 14.91$). With respect to education, all but twelve respondents earned a high school diploma (or General Educational Development (GED) certificate), with some earning Associate's ($n = 27$), Bachelor's ($n = 22$) or Doctoral ($n = 4$) degrees. Over 40 per cent of the sample were married ($n = 51$) and 21 per cent were living

with a partner ($n=26$). The respondents had an average of 3.77 children ($SD=2.37$) and the majority worked full-time ($n=85$; 66.93 per cent).

Measures

Depressive symptoms: The frequency of an individual's depressive symptoms were measured by the Patient Health Questionnaire-9 (PHQ-9; Kroenke *et al.*, 2001), a tool used and recommended for use with Indigenous peoples (Urban Indian Health Institute, 2012). Participant's indicated how often over the past two weeks they were bothered by 'Feeling down, depressed, or hopeless', 'Feeling tired or having little energy' and 'Trouble falling or staying asleep, or sleeping too much'. For each of the nine items, four response options were available. These were 0 = 'not at all', 1 = 'several days', 2 = 'more than half the days' and 3 = 'nearly every day'. When summed, the nine-scale items had a possible range of 0–27 and the total score corresponded to an individual's level of depressive symptoms along a continuum that was scored as: minimal (score of 0–4), mild (5–9), moderate (10–14), moderately severe (15–19) and severe (20–27) depression. PHQ-9 scores of 10 or higher indicate clinical depression, a cut point validated across numerous studies (Pratt and Brody, 2008). Cronbach's alpha for the study sample was 0.92.

Historical oppression: Historical oppression was measured by the ten-item Historical Oppression Scale (Burnette *et al.*, 2018). The scale was created from emergent qualitative results and the conceptual framework (see Supplementary Appendix A). Respondents were asked to indicate the extent that they perceived members of their community engaged in behaviours as a result of historical events (experiencing discrimination, oppression and mistreatment by outsiders). The behaviours included, 'Have taken out frustrations on each other and hurt each other (through family and community violence)' (i.e. sub-oppression/horizontal violence), 'Not received adequate education or resources' (i.e. marginalisation), 'Treated each other unfairly' (i.e. sub-oppression) and 'Had lower standards and expectations for each other' (i.e. internalised oppression). Responses were assessed using a five-point scale ranging from 'not at all' to 'a great deal'. Responses were summed and higher values indicated greater a higher degree of historical oppression (range = 10–50). Cronbach's alpha for the sample was 0.97.

Proximal stressors: An eleven-item scale, inspired by the Hassles Scale (Kanner *et al.*, 1981) and the Social Readjustment Rating Scale (Holmes and Rahe, 1967), was used to measure one of two proximal stressors. This shortened scale (to reduce survey length) consisted of eleven items evaluating the worry or stress associated with events of daily living in the past month (i.e. daily hassles). Items focused on worries related to

food and shelter, money for paying bills, moving, work problems, problems with family and friends and generally feeling overloaded. Response items ranged on a four-point scale from 'not at all' to 'very much'. The scale ranged from 11 to 44, with higher scores indicating greater stress or worry over daily hassles. Cronbach's alpha for the study sample was 0.85.

Income: Income was included as the second of two proximal stressors. Each respondent provided information on their annual household income. The nine response options ranged from '1 = less than \$2,000' to '9 = greater than \$100,000'.

Family resilience: Family resilience was assessed through the twenty-item family resilience inventory subscale, a scale of one's current family protective and promotive factors (Burnette *et al.*, 2019), which was created from emergent qualitative results (see Supplementary Appendix B). Respondents were asked to indicate whether each item was generally true for their current family (yes/no). Items included, 'We have family members to look up to', 'We have strong values that guides our actions' and 'We work together to help each other and to complete goals.' The total ranged from 0 to 20 with higher values indicating greater family resilience. Cronbach's alpha for the study sample was 0.88.

Life satisfaction: Life satisfaction was measured using the Satisfaction with Life Scale (SWLS) (Diener *et al.*, 1985). Researchers have examined life satisfaction amongst Indigenous peoples using this scale (Roh *et al.*, 2015c). The SWLS is a five-item scale designed to measure global judgements about one's life satisfaction. Respondents indicated how much they agreed or disagreed with each of the five items using a seven-point scale that ranged from 'strongly disagree' to 'strongly agree'. Items included, 'I am satisfied with my life', 'The conditions of my life are excellent' and 'So far I have gotten the important things I want in life'. The summed scale ranged from 5 to 35, with higher scores indicating greater life satisfaction. Cronbach's alpha for the study sample was 0.90.

Data analysis

The analyses proceeded in two steps. First, we examined the bivariate relationships between the independent variables (e.g. historical oppression, income, family resilience) and depressive symptoms, following the conceptual model. We also investigated the association between covariates, such as age, gender and tribal membership, and the outcome. Second, we used linear regression to examine the multivariate main effects of the predictor variables. To create a parsimonious multivariate model for depressive symptoms, we entered a variable into the model if it was related to the dependent variable in the bivariate analyses at the

$p < 0.05$ level. Historical oppression ($r = 0.309$; $p = 0.001$), proximal stressors ($r = 0.610$; $p = 0.000$), income ($r = 0.278$; $p = 0.002$), family resilience ($r = -0.494$; $p = 0.000$) and life satisfaction ($r = -0.495$; $p = 0.000$) were statistically significantly associated with depressive symptoms. Gender ($t = -1.074$; $p = 0.285$), age ($r = -0.162$; $p = 0.069$) and tribal membership ($t = 0.085$; $p = 0.993$) were not statistically significantly associated with depressive symptoms. Thus, these latter variables were not included as covariates in the final model. All analyses were performed using SPSS Version 25 software (IBM Corp, 2017).

Results

With respect to the depressive symptoms, the average PHQ-9 score amongst the survey participants was 6.30 (SD = 6.63, range = 1–27), which corresponds with mild depression. The respondents' reported moderate historical oppression ($M = 31.24$, SD = 13.35, range = 10–50) and moderate proximal stressors ($M = 23.99$, SD = 7.06, range = 11–44). The majority of respondents reported an annual household income level that was between \$25,001 and \$50,000. The respondents' reported high family resilience ($M = 18.03$, SD = 3.22, range = 0–20) and moderate life satisfaction ($M = 23.95$, SD = 6.68, range = 5–35). This latter level is slightly lower than the life satisfaction score found amongst an Indigenous sample of older adults from the upper Midwest using the same measure (Roh *et al.*, 2015c).

At the bivariate level, each of the independent variables was significantly associated with the dependent variable, depressive symptoms, in the expected direction—which supported our hypotheses. The variables in the multivariate linear regression model accounted for 53.6 per cent of the explained variability in depressive symptoms (adjusted $R^2 = 0.536$, $F(5, 115) = 27.60$, $p = 0.000$). The regression results (see Table 1) revealed further support that the four hypotheses were upheld after controlling for other variables in the model. Higher levels of historical oppression were positively associated with higher reports of depressive symptoms ($\beta = 0.18$, $p = 0.012$). A positive relationship was found between proximal stress and depressive symptoms ($\beta = 0.38$, $p = 0.000$) and a negative relationship was found between income and depressive symptoms ($\beta = -0.21$, $p = 0.002$). This indicates that respondents who reported more stress in daily living (i.e. proximal stress) also reported more depressive symptoms and respondents who reported higher incomes reported fewer depressive symptoms. Family resilience ($\beta = -0.25$, $p = 0.001$) had significant negative regression weights, indicating respondents with higher resilience reported lower depressive symptoms. Finally, greater life satisfaction was associated with lower depressive symptoms ($\beta = -0.18$, $p = 0.023$).

Table 1 Historical oppression, resilience, transcendence (life satisfaction) and depressive symptoms

Variable	<i>B</i> (SE)	β	<i>p</i>
Historical oppression	0.09 (0.03)	0.18	0.012
Proximal stressors	0.36 (0.07)	0.38	0.000
Family resilience	−0.52 (0.15)	−0.25	0.001
Life satisfaction	−0.18 (0.08)	−0.18	0.023
Income	−0.76 (0.24)	−0.21	0.002

Unstandardised beta (*B*), the standard error for the unstandardised beta (SE) and the probability value (*p*).

Discussion

The results of our study reveal an empirical connection between historical oppression and the mental well-being of Indigenous peoples. Several priorities outlined by the UN's Sustainable Development Goals are encompassed in this model, such as poverty (income), good health and well-being and reduced inequalities (United Nations, 2018). Preliminary support for the FHORT as it relates to depressive symptoms amongst Indigenous peoples is an important step in connecting structural causes to contemporary health and well-being. Our research highlights several findings of note. On average, respondents reported a mild level of depression; yet, 25 per cent of participants reported clinical levels of depression, in comparison with 5.4 per cent of the general US population (Pratt and Brody, 2008). This validates the pervasive disparity in depression amongst Indigenous populations. In addition to providing this important prevalence data, the Framework was largely supported by our research. Hypothesis 1 was supported, as perceived historical oppression was confirmed to be positively associated with depression. Although a limitation of prior research has been the absence of the ability to empirically connect historical oppression to mental health outcomes, such as depression (Burnette and Figley, 2017), our study was able to bridge this gap. The findings indicate that at least some members of two Southeastern tribes perceive that broad historical oppression and trauma continue to have contemporary effects on peoples' wellness and mental health and the poor health and social outcomes are consequences of broader oppression.

Proximal stress, in the forms of lower income and greater daily stress were also found to be positively associated with depression (Hypothesis 2). In addition to broader oppression, researchers have found that Indigenous peoples continue to be overburdened with daily stress and income inequality (Gone and Trimble, 2012). It is not only historical trauma or contemporary stress that give rise to negative mental health outcomes but the pile-up of risk factors that make it more difficult to cope. Thus, the underlying factors that give rise to depression may be found both in the past and the present.

Finally, Hypotheses 3 and 4 were supported: family resilience and life satisfaction were negatively associated with depressive symptoms, indicating their potentially protective function. It is not enough to follow the trend of most research with Indigenous peoples, which examines risk factors (Burnette and Figley, 2016). We must also understand pathways towards health and wellness in order to capitalise on existing strengths and resources at various levels of the environment. Families are one such promising resource to build upon.

In prior work with Indigenous peoples, researchers identified families as being especially important for whether people can heal from experiences of intimate partner violence more expediently or experience continued struggles (Burnette and Figley, 2017; Dalla *et al.*, 2010). The current study mirrors support for this finding as family resilience was protective against depressive symptoms. This provides an important foundation to build family-focused interventions related to the health and wellness of Indigenous individuals and families.

Finally, life satisfaction was positively associated with depression. This finding indicates that being generally satisfied with life, in spite of experiencing daily stress and historical oppression, helps people endure and potentially overcome their depressive symptoms. Mental health professionals can use this research to find ways to enhance family resilience and identify the factors that enable individuals to transcend oppression, and nurture these qualities in a culturally relevant way.

Because Indigenous populations experience serious psychological distress at 1.5 times the rate of the general population (American Psychological Association, 2010), it is imperative that clinicians become better equipped to provide assistance. Clinicians need not only to attend to the symptoms but to the underlying risk factors leading to depression in this population. More efforts should be made to enhance protective factors such as enhancing social support, especially from family members. This also includes efforts to enhance family resilience. Underlying potential causes of depression, such as historical oppression, need to be addressed and incorporated into prevention and treatment models. For example, White Bison uses a 'healing forest model' that uses a framework parallel to FHORT in order to understand how historical oppression has made families and communities sick (Moore and Coyhis, 2010). Thus, the FHORT may serve as a useful tool in organising resources and interventions to lower depression whilst bolstering family resilience.

Strengths and limitations

A of our study was the use of in-depth culturally grounded research to inform culturally relevant scales of historical oppression and family resilience, which, despite a relatively small sample size, did show significant

associations with depressive symptoms. As with all studies, there were limitations to our work. All variables were assessed via self-report measures. In this way, perceptions of historical oppression and its effects were measured but could not be directly observed. Although variables were positively and negatively associated with depressive symptoms in the direction hypothesised, further research, including moderation and mediation analysis, is necessary to further confirm their risk and/or protective functions and whether they were protective or promotive in nature. More analysis examining the cumulative effect of risk and protective factors is also warranted. Other important variables, such as ethnic identity, may be important factors, but were not found to be significant in this study; future research with larger samples may glean important results. Although we have no reason to believe study participants were enhancing or under-reporting their experiences, it is important to acknowledge that all information was gathered through a single source. This research represents an important step forward for supporting the Framework and reporting results for two tribes in the Southeast USA; however, the findings are not generalisable to members of other Indigenous populations. Moreover, some variables, such as gender, age and enculturation, were not found to be significantly associated with the outcome of interest. Given the diversity of Indigenous peoples, these findings requires further investigation across distinct context and with larger samples for a fuller understanding.

Future research and implications for practice

More work is needed to replicate our findings with other populations and to further test the utility of the FHORT for explaining mental health outcomes, including but not limited to depressive symptoms. Researchers must continue to extend their examination of disparities to people who span various physical and social health dimensions. These disparities are interconnected and it is important to also focus on the various strengths and protective factors that are present amongst Indigenous individuals, families and communities to eradicate disparities and meet the trust responsibilities to provide for the health and well-being of Indigenous peoples. Practitioners should look to strengthen culturally relevant protective factors, namely family resilience, as a sustainable and organic source of strength for Indigenous peoples struggling with depression. The protective factors on the Family Resilience Inventory are useful in strengthening and supporting the existing pathways towards resilience. Social workers should situate disparities in the culturally specific context of historical oppression so as to not misinterpret mental health problems without having structural causes. As such,

the FHORT is useful in practice for understanding depression and other disparities in a culturally relevant way.

The results from this study were reported to the tribes on over ten occasions. A CBPR approach was used and a community advisory board (CAB) has developed a culturally relevant and effective intervention that addresses the challenges that were uncovered through this research, as well as ways to promote various strengths. Through the CAB, tribal members were trained to facilitate the intervention and the researchers partnered with tribal non-profit organisations to develop this programme. In this way, after close to ten years of community-engaged work, the current research has come full circle in creating transformative change to address the negative effects of historical oppression through the re-envisioning and building upon the many strengths of Indigenous communities (e.g. family resilience).

Supplementary material

[Supplementary material](#) is available at *British Journal of Social Work* online.

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