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American Indian Historical Trauma: Anti-Colonial Prescriptions for Healing, Resilience, and Survivance

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Abstract

The American Indian historical trauma (HT) concept is an important precursor to racial trauma (RT) theory that reflects the distinct interests of sovereign Indigenous nations but shares much of the same promise and challenge. Here, that promise and challenge is explored by tracing HT's theoretical development in terms of its anti-colonial ambitions and organizing ideas. Three predominant modes of engaging HT were distilled form the literature (HT as a *clinical condition, life stressor*, and *critical discourse*), each informing a research program pursuing a different anti-colonial ambition (*healing trauma, promoting resilience, practicing survivance*) organized by distinct ideas about colonization, wellness, and Indigeneity. Through critical reflection on these different ambitions and dialogue of their organizing ideas, conflict between research programs can be mitigated and a more productive anti-colonialism realized in psychology and related health fields. Key recommendations emphasized clarifying clinical concepts (e.g., clinical syndrome vs. idiom of distress), disentangling clinical narratives of individual pathology (e.g., trauma) from social narratives of population adversity (e.g., survivance stories), attending to features of settler-colonialism not easily captured by heath indices (e.g., structural violence), and encouraging alignment of anti-colonial efforts with constructive critiques establishing conceptual bridges to disciplines that can help to advance psychological understandings of colonization and Indigenous wellness (e.g., postcolonial studies). This conceptual framework was applied to the RT literature to elaborate similar recommendations for advancing RT theory and the interests of ethnic/racial minority populations through engagement with psychology and related health fields.

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Keywords

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In recent decades, the psychological literature has been scrutinized concerning its relevance for marginalized populations such as racial/ethnic minorities, Indigenous peoples, and diverse communities around the globe (e.g., Arnett, 2008; Hartmann et al., 2013; Henrich, Heine, & Norenzayan, 2010). In addition to relying heavily on homogeneous and relatively privileged samples (e.g., White American undergraduate students; Arnett, 2008; Henrich, Heine, & Norenzayan, 2010), psychological research has focused on presumed universal cognitive, behavioral, and biological processes that are not of particular relevance to the life experiences and pressing socio-political problems facing many minority groups (e.g., racism, poverty, discrimination, oppression; Cundiff, 2012; Hartmann et al., 2013). As the populations of Western nations become increasingly diverse with racial/ethnic minorities on track to outnumber non-Hispanic/Latino Whites in the U.S. by 2050 (U.S. Census Bureau, 2010), gaps between the established body of psychological knowledge and lived experiences of racial/ethnic minorities may widen further, calling into question psychology's relevance for a soon-to-be majority of Americans. Therefore, in addition to structural changes needed to narrow this relevancy gap for the discipline (e.g., diversifying faculty, funding contextualist inquiry), it is imperative that psychologists devote greater attention to theories and problems of relevance to these populations.

Research on racial trauma (RT) represents one of several promising efforts to develop a more inclusive and relevant body of knowledge for the discipline. RT theory ties hardship to contexts of oppression with an expanded trauma concept to recognize and understand, rather than ignore, the effects of societal oppression for racial/ethnic minorities (Bryant-Davis & Ocampo, 2005; Carter, 2007; Comas-Diaz, 2016). According to Carter (2007), this wedding of racial discrimination to stress more generally, and to traumatic stress specifically, was intended to "allow for an analysis of the relation between a particular type of racist act or experience [and] a person's emotional and psychological reactions and its subsequent mental health effect" (p. 25). Developing the RT concept was thus a bid to incorporate routine and pervasive experiences of racial discrimination into established constructs related to psychological injury, such as posttraumatic stress disorder (PTSD). Although there can be little doubt that racism takes a profound psychological toll on people of color (APA, 2017; Carter, 2007; Pascoe & Richman, 2009), challenges remain for conceptualizing RT in light of the shifting meanings of "trauma" and its unclear associations to related concepts such as microaggressions, stereotype threat, and racial oppression. These challenges have implications for how psychologists conceptualize race and respond to racism as researchers, practitioners, and policymakers. Fortunately, RT is not the first expanded trauma concept modeled on PTSD to capture and represent hardship stemming from oppression. Lessons for navigating these challenges can be gleaned from an examination of the successes and unresolved tensions of a predecessor of RT: historical trauma (HT).

This article will consider theoretical complexities that inhere in the promotion of RT (and related constructs) through a focus on HT among American Indians (AIs). Although

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subsequent terms have been developed tailoring the HT concept to experiences and circumstances of Indigenous populations outside the continental U.S. (e.g., Aboriginal HT, Native Hawaiian HT), as a conceptual review of the HT concept this article focuses on its original framework as AI HT. Both RT and HT represent conceptual extensions or elaborations on psychological injury as captured by clinical PTSD. Indeed, the RT concept references empirical literature on the physical and mental health effects of race-based discrimination (Carter, 2007; Comas-Diaz, 2016), but its adoption of the trauma term and framework capturing psychological injury from experiences of oppression closely mirrors the HT concept. However, the promise and challenge of attributing psychological distress from experiences of oppression through the mechanism of traumatic stress has been contested for decades. This is especially true for HT, where instances of oppression that most dramatically impact current functioning are posited to have happened to one's ancestors.

In this article, the theoretical validity and utility of HT is assessed in light of the anti-colonial ambitions of its proponents to improve the health and wellness of AI peoples. Key to this analysis is an exploration of unresolved tensions between three distinct engagements with the HT concept as a *clinical condition, life stressor*, and *critical discourse*, each allowing its proponents to pursue ambitions related to *healing trauma, promoting resilience*, and *practicing survivance* with AI peoples through engaging psychology and related health fields. "Survivance" in postcolonial literature is a purposefully inexact notion introduced by Anishinaabe cultural theorist Gerald Vizenor (1999) to counter social narratives of "victimry"—in which AIs are depicted as mere survivors, existing in the ruins of former greatness—with a genre of creative action asserting continued Native presence and vitality. Although we begin by categorizing each engagement with HT according to its distinguishing ideas and ambitions, we then situate each category as a position taken by HT scholars along a continuum spanning in focus from the intra-personal to the socio-structural in expressing shared anti-colonial commitments to resisting colonial violence as part of, if not prerequisite for, supporting AI health and wellness. As an inclusive term for resisting colonial violence, "anti-colonial" is meant to encompass multiple, overlapping frameworks, including "tribal nationalism" advanced by the Red Power movement to foreground tribal sovereignty and self-determination in negotiations with the U.S. settler-state (Deloria, 1969), "decolonial theory" from the Global South where Indigenous peoples contended with colonialisms of resource extraction more often than displacement and land dispossession per settler-colonialism (for a review of decolonial theory see Adams, Dobles, Gómez, Kurti , & Molina, 2015), and "postcolonial theory" originated by scholars seeking to transcend colonizer-colonized binaries to examine power relations maintaining conditions of oppression (see Moore-Gilbert, 1997). While disentangling theory and praxis for each framework is beyond the scope of this article, recognizing the existence of multiple anti-colonial strategies informs the following analysis of different anti-colonial ambitions advanced through each engagement with HT.

American Indian Historical Trauma

The HT concept was principally developed by Maria Yellow Horse Brave Heart to illuminate professionally unrecognized causal contributions of colonization to AI behavioral health

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(BH) disparities and re-conceptualize AI hardship in a way that "avoids victim blaming and pathologizing" (Brave Heart, 1995, p. 8). Importantly, Brave Heart with Eduardo and Bonnie Duran—also major contributors to the conceptual development of HT—understood their promotion of HT as part of an anti-colonial initiative in psychology. Brave Heart identified her work among "clinical activist strategies" empowering "indigenous people throughout the world" to overcome "historical legacies" of colonization (Brave Heart & DeBruyn, 1998, p. 76), and E. and B. Duran connected their work to Fanon's (1963) argument for colonial expulsion and indigenous renewal, proclaiming, "in keeping with the spirit of our brother Fanon… [we] must create knowledge that is not only new, but is also liberating and healing" (Duran & Duran, 1995, p. 6). Thus, at the heart of the HT concept has always been a motivating anti-colonial ambition to shed light on pernicious effects of colonization in the lives of contemporary AIs and re-configure professional and lay narratives about AI BH disparities to better facilitate their amelioration.

To accomplish this task, these three clinician-scholars developed a new trauma concept, HT, to historically contextualize AI BH disparities with reference to colonization. Brave Heart began by comparing the European colonization of North America to the Jewish Holocaust (e.g., "The American Indian Holocaust"; Brave Heart & DeBruyn, 1998) and adopting theories of cross-generational trauma transmission from a body of psychoanalytic literature on descendants of Jewish Holocaust survivors (Brave Heart, 1995; 2003). These theories involved subconscious psychological processes of transposition, loyalty to the deceased, and memorial candles, which Brave Heart then adapted to reflect her understanding (as Lakota) of "traditional Lakota history and culture" (Brave Heart, 1995, p. 8). For example, where memorial candles (i.e., children of Holocaust survivors that subconsciously internalized ancestral trauma) had been conceptualized in a two-parent nuclear family structure, Brave Heart modified the idea to become "memorial people" reflecting traditional Lakota extended family units (Brave Heart, 1998, p. 292). From this theoretical foundation, Brave Heart and E. and B. Duran began describing a distinctly AI "trauma response" to colonization that emphasized a deep "emotional and psychic wounding" among contemporary AIs (Brave Heart, 1995, p. 8; see also Brave Heart, 1999; 2003; Duran, 1984; 1990; Duran & Duran, 1995). In doing so, the HT concept combined historical oppression and psychological injury in novel fashion, which Hartmann and Gone (2014) summarized with "four Cs": *collective experience* of *colonial injury* with *cumulative effects* snowballing to produce *cross-generational impacts* that increase risk for BH problems among AIs today. Since its introduction to the literature in 1995, the HT concept electrified fields of AI BH and quickly grew in popularity: from 16 to 39 to 99 mentions, respectfully, in 1996–2002, 2003–2009, and 2010–2016, per a PsycINFO abstract search on December 19, 2017 (search terms: MM "American Indian" and "historical trauma"). However, amidst increasing popularity, the "history" and "trauma" of HT have been reformulated by scholars from different disciplines preferring alternative theoretical frameworks and research paradigms. Although malleability of the trauma term may have contributed to the concept's popularity, it also fed a conceptual haze in which multiple HT concepts emerged within divergent programs of research organized around varying ideas of *colonization, wellness*, and *Indigeneity* to pursue distinct anti-colonial ambitions for improving the lives of AIs. This confusion has arguably become a barrier to advancing HT theory and realizing a more productive, multi-tiered anti-

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colonialism in psychology and health. To resolve this confusion, we distil three predominant modes of engagement with HT from the literature—clinical condition, life stressor, critical discourse—and detail their respective research programs in terms of organizing ideas and anti-colonial ambitions. For each "research program" (i.e., the collective works of HT researchers informed by particular mode of engaging HT), we describe its promise and challenge to offer recommendations for advancing common goals of improving the lives of AIs through engagement with psychology and related health fields.

HT as a Clinical Condition

The first research program to emerge engaged HT as a clinical condition. This research can be traced to the concept's earliest iterations, namely the "HT response" (Brave Heart, 1995) and "soul wound" (Duran, 1990), which blended psychoanalytic theories of trauma with the authors' understandings of AI cultures to create an expanded trauma concept modeled on PTSD. Just as Herman (1992) advanced a "complex PTSD" diagnosis to capture complexities beyond "simple PTSD," the HT response and soul wound were described as synonymous terms for an "intergenerational PTSD" that captured complexities specific to AI experiences of colonization and came to be known simply as "historical trauma" (Brave Heart, 1995; 1999; Duran & Duran, 1995). Brave Heart (2003) noted HT "described massive cumulative trauma across generations rather than the more limited diagnosis of… PTSD, which is inadequate in capturing the influence and attributes of Native trauma" (pp. 7–8). Distinctive influences or causes for this clinical condition included lost land, language, and culture (Brave Heart, 1999), and its attributes or symptoms included "depression and self-destructive behavior, substance abuse, identification with the ancestral pain, fixation to trauma, somatic symptoms, anxiety, guilt, and chronic bereavement" (Brave Heart, 1999, p. 111). To make historical oppression relevant to the psychological study of AI hardship today, then, HT was introduced as a clinical condition with a familiar symptom profile combining features of PTSD, complicated bereavement, and "survivor syndrome" (see Niederland, 1968).

In introducing HT as a recognizable clinical condition these efforts sought professional recognition to garner support from the clinical establishment for developing and implementing more effective, culturally-informed psychotherapeutic interventions. Seeking this support, Brave Heart and E. and B. Duran underscored the ineffectiveness of standard psychotherapies to justify AI-specific alternatives. Duran (1984) attributed this ineffectiveness to different worldviews shaping "the Native American psyche" (p. 39) and its Euro-American counterpart, differences he thought to bridge in "analytic and archetypal therapy" (p. 87) adapting Jungian archetypes to reflect traditional AI concepts of illness and healing. Similarly, Brave Heart delved into Lakota culture and history to distinguish HT from other trauma concepts and experiences they captured before proposing a clinician-administered "psychoeducational group intervention" (Brave Heart, 1998, p. 287). This program, Brave Heart (1999) explained, could "initiate a healing response" by facilitating "heightened awareness of [HT]… a trauma resolution process, and stimulation of re-cathexis (re-attachment) to traditional Lakota values" (p. 110). Thus, HT was introduced as a clinical condition making novel causal claims that tied historical oppression to psychological injury,

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and the remedy for this injury was more effective clinical interventions incorporating AI cultural forms into familiar psychotherapeutic frameworks (i.e., therapy by therapists).

This construction of HT has engaged psychology and health literatures to advance an anti-colonialism of healing trauma by introducing a clinical condition that justifies culturally-informed psychotherapies for AIs. Behind this interest in trauma treatment are influential ideas about colonization, wellness, and Indigeneity. In this work, colonization is described as a traumatic past event with consequences of psychological injury, like PTSD. This is evident in regular comparisons to the Jewish Holocaust and clinical descriptions of the HT condition. For example, one participant in Brave Heart's Lakota intervention shared: "I had a dream the other day. It was kind of scary. I got up shaking [starting to cry]. I saw people carrying guns and shooting people [American Indians] in the Black Hills again. It was a hard dream" (Brave Heart, 1998, p. 72). Here, like other illustrations of HT in this research program, colonization is a historical event (e.g., a massacre) resulting in a recognizable pattern of psychological injury (e.g., distressing nightmares similar to PTSD). Wellness, in turn, is described as a restoration of health among intervention participants, often documented in symptom alleviation. For example, to communicate intervention effectiveness, Brave Heart (1998, p. 296) detailed post-intervention reductions in negative emotions (e.g., grief, sadness, guilt) and E. Duran (1990, pp. 105–106) noted improved school performance, reduced wetting, and promising symbolic play for a child client. Indigeneity in this clinical framework is indicative of membership in a trauma-affected population. Brave Heart and E. and B. Duran have gestured toward a diversity of trauma responses for different AI populations, however, these differences have been left unexplored to the effect of tying Indigenous ancestry to psychological injury from a collective history of colonization. Engaging HT as a recognizable clinical condition thus opened a door to developing culturally-informed psychotherapies that could better advance the clinical interests of AI peoples.

HT as a Life Stressor

While early theorists conceptualized HT as a diagnosable clinical condition, a second generation of HT scholars emerged—many from public health—to recast HT as a life stressor. These scholars saw promise in shifting HT's trauma theory from its clinical origins in traumatic memory and psychological injury to an extra-clinical and less psychological "stress-coping" paradigm (Walters & Simoni, 2002). Professional recognition, then, hinged on recognition of HT's stress effects in prominent health fields. This shift involved reinterpreting the trauma of HT as a high degree of stress (i.e., a "traumatic stressor" [Walters et al., 2011, p. 182]) rather than a discrete category of experience, and re-focusing inquiry on documenting harmful stress effects of HT on AI health (Evans-Campbell, 2008; Walls & Whitbeck, 2012; Walters & Simoni, 2002). This new direction, accelerated by the creation of the Historical Loss Scale (Whitbeck, Adams, Hoyt, & Chin, 2004), is apparent in Karina Walters' "Indigenist stress-coping model" (Walters & Simoni, 2002) and Teresa Evans-Campbell's "multi-level framework" (Evans-Campbell, 2008). Both models maintained the language of healing from earlier HT works but used it to reference health prevention and promotion strategies, not individual or small-group psychotherapy.

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In place of trauma treatment, engaging HT as a life stressor has encouraged community interventions to prevent stressors, like HT, from impacting the health of AIs. In addition to familiar coping skills and harm reduction strategies, this work has promoted "cultural factors… as buffers" mediating the impact of HT (and other stressors) on AI health outcomes (Walters & Simoni, 2002, p. 521). Walls and Whitbeck (2012) reasoned, "the negative impact of historical loss on mental health as a culturally specific stressor might… be buffered by involvement in traditional cultural activities or a strong cultural identity" (p. 418). Among potential buffers, Walters and Simoni (2002) indicated identity attitudes, enculturation processes, spiritual coping, and traditional health practices, which HT researchers have since explored in mediation studies. The mediating effects of cultural identity, for example, have been studied in terms of its strength (e.g., Soto, Baezconde-Garbanati, Schwartz, & Unger, 2015), centrality (e.g., Bombay, Matheson, Anisman, & Zarate, 2014), and related attitudes (e.g., Tucker, Wingate, & O'Keefe, 2016). Meanwhile, health interventionists have drawn upon this work to implement programs intended to bolster these cultural factors. The "Our Life" intervention by Goodkind, LaNoue, Lee, Freeland, and Freund (2012) exemplified this genre in its effort to "promote youth mental health and reduce youth violence" by "recognizing and healing historical trauma; reconnecting to traditional culture… sharing culturally appropriate parenting practices and social skills… and building relationships between parents and youth" (p. 470). Here, healing HT entailed "recognizing" harm from colonial oppression and providing opportunities to engage protective cultural factors (e.g., "reconnecting to traditional culture" and "building [family] relationships"). Engaging HT as a life stressor has thus pulled for community health interventions that include protective cultural factors to inoculate AIs against stress-effects from histories of colonization.

This HT research advances an anti-colonialism of promoting resilience by elucidating relations between life stressors and protective cultural factors, thereby justifying health programs that help to further develop these cultural factors alongside standard coping skills and harm reduction strategies. This shift from clinical trauma to clinical stress was guided by different ideas about colonization, wellness, and Indigeneity. Colonization is still mentioned as a historical event, but its direct effect as one of many life stressors invites attention to compounding stressors in AIs' postcolonial environment (e.g., discrimination; Walters, Simoni, & Evans-Campbell, 2002; Walls & Whitbeck, 2012). Walters et al. (2011) explained that AIs "have suffered… historical experiences of European colonization *and* the ongoing contemporary effects of colonization (e.g., oppression)" (p. 180, emphasis added), brining attention to both historical and contemporary experiences with colonial oppression. Wellness, measured via community health indicators, focuses on reducing the stress-effects of past and present colonial oppression via participatory intervention that foster engagement with protective cultural resources (e.g., traditional activities, see Coe et al., 2004) and prevent problem behaviors (e.g., substance use, see Kulis, Hodge, Ayers, Brown, & Marsiglia, 2014). Indigeneity in this research program is dually characterized by inhabiting a "colonized or fourth world position" of vulnerability due to life stressors (Walters & Simoni, 2002, p. 520) and maintaining privileged access to cultural resources that can buffer stress effects and facilitate resilient health outcomes. Thus, if histories of colonization are one of many sources of stress for contemporary AIs, community health programming is critically

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important, and if cultural factors can buffer these effects, then their identification and incorporation into interventions is vital for promoting AI resilience.

HT as a Critical Discourse

Whereas the previous two HT research programs took AI BH disparities to be fueled by a clinical condition or life stressor and therefore amenable to psychological or health inquiry and intervention, a third HT research program developed questioning the utility of psychology and health fields for supporting AI wellness. As such, this research program engaged HT as a critical discourse to rhetorically critique predominant psychological and health framings of AI hardship. These efforts can be traced to the HT concept's international debut in the first compilation of research on multi-generational effects of trauma (Danieli, 1998). There, descriptions of HT as an intergenerational PTSD were questioned for promoting an overly "psychological" discourse of trauma (Gagné, 1998, p. 355). In its place, Gagné advanced a "sociological discussion" of trauma, not as an intra-personal injury, but a socio-political "metaphor" contextualizing AI hardship in relation to colonial arrangements that maintain "economic and social dependence" on the settler state (p.356). Such resistance to reductionist narratives of human hardship is common to critical discourse in psychology and health where attention to discourse can illuminate how popular psychological and health framings of adversity eclipse attention to socio-economic, cultural, and structural factors in favor of a less political focus on intra-personal injury or deficit (Caplan & Nelson, 1973; Gone, 2007; Metzl & Kirkland, 2010; Prilleltensky, 1989). Where the HT literature appears to reproduce these patterns (e.g., "psychologizing" or "medicalizing" AI hardship to locate dysfunction in the individual instead of shared circumstances), these scholars have raised alarm (Denham, 2008; Gone, 2014; Hartmann & Gone, 2014; 2016; Maxwell, 2014).

Rather than focus on the HT concept, which the previous two research programs used to make psychology and health fields more relevant for AI peoples, these scholars have offered contextualist analyses of HT discourse in scientific literatures and AI communities. As such, this diffuse body of work has explored patterns of thought expressed through (and structured by) the language of HT to understand unintended consequences of applying psychological and health frameworks to issues of AI hardship and wellness. Of particular concern has been the application of HT's clinical trauma template to conceptualizations of colonization and its contributions to AI hardship, which these scholars have argued facilitates a pervasive focus on psychological injury and vulnerability with unintended consequences of pathologizing Indigeneity and obfuscating colonial systems and structures that reproduce AI hardship (Denham, 2008; Gone, 2014; Maxwell, 2014). HT's trauma template, modeled on PTSD and tied to the trauma term, has also been implicated in misrepresenting AI histories and contributing to an erasure of AI peoples (Gone, 2014; Hartmann & Gone, 2016). Evans-Campbell (2008) hinted at a similar concern in mentioning the "most insidious" impacts of HT from "historical assaults on AI… culture, social structures, and ways of life" have received "limited discussion in the literature… using a trauma framework" (p. 327). Scholars engaging HT as a critical discourse attribute this attentional bias to the clinical and health frameworks themselves (e.g., stress, psychopathology), which pull for a reductionist focus on clinical symptoms and health behaviors. In response, these scholars have proposed either redefining HT as "public narrative" (i.e., not a clinical or health issue) to situate it outside

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common clinical and health discourse (see Mohatt, Thompson, Thai, & Tebes, 2014) or replacing the HT concept with a term that does not invoke trauma or imply injury (e.g., “postcolonial distress”; Kirmayer, Gone, & Moses 2014). As a discourse, then, HT operates as a site of conceptual exchange between AI peoples, psychology, and health fields that shapes understandings of AI hardship, health, and wellness, and as such, these scholars bring critical attention to HT discourse so as to ascertain unapparent consequences of these exchanges.

Meeting psychology and health fields with critique to constrain their influence over AI peoples so as to avoid pathologizing AI individuals or communities, scholars engaging HT as a critical discourse advance an anti-colonialism of practicing survivance. As a survivance strategy, these critiques challenge colonial arrangements in psychology and health that work against AI sovereignty and self-determination while introducing new ideas of colonization, wellness, and Indigeneity that serve these socio-political interests. Rather than an event, this research presents colonization as an ongoing process of negotiation between AI peoples and a settler state that endeavors to naturalize its existence and territorial sovereignty by erasing AI peoples (Veracini, 2014; Wolfe, 2006). This negotiation unfolds in recurrent relational formations, which can be overtly violent (e.g., military action), but often emerges subtly in familiar systems and structures. Maxwell (2014) illustrated this subtle emergence in comparing historical collusion between social services and the settler state to representations of “problem parenting” in the HT literature. Wellness is explored as a localized cultural construction with individual, community, and political dimensions requiring attention beyond health to consider systems and structures that facilitate and undermine AIs’ ability to create healthy, meaningful lives in culturally vibrant nations (e.g., Kirmayer et al., 2014; Prussing, 2014; Waldram, 2014). Through attention to HT discourse, these scholars have found important barriers to AI wellness embedded in psychology and health fields (e.g., a pull for a-political, reductionist analyses of AI hardship; Hartmann & Gone, 2014; 2016). Referencing political theory from Indigenous Studies (e.g., Coulthard, 2007), this research emphasizes Indigeneity as a political claim to citizenship, not a social identity, to foreground the socio-political interests of tribal nations that are often absent in discussions of AI health and wellness. Although some of these organizing ideas may appeal to HT scholars in other research programs, critical inquiry into HT discourse has questioned the suitability of HT, engaged as a clinical condition or life stressor, for accommodating these ideas and advancing AI socio-political interests through psychology and related health fields.

Anti-Colonial Prescriptions

In contributing to each research program, scholars have brought much-needed attention to HT’s organizing ideas, and in the process, introduced three anti-colonial initiatives aiming to advance the clinical, health, and socio-political interests of AI peoples while narrowing the relevancy gap for psychology. However, given HT scholars’ different, and at times conflicting, ideas about how anti-colonial efforts should be organized and pursued in relation to psychology and health fields, it is important HT researchers consider the anti-colonial initiatives their work advances, the underlying ideas about Indigenous wellness it promotes, and how different anti-colonial efforts can be better aligned to pursue mutual goals of AI health and wellness. We now turn to elaborating the anti-colonial initiative of each HT

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research program to identify challenges and suggest means for advancing different interests by engaging psychology and health fields.

Healing Trauma

The first research program engaged HT as a clinical condition and advanced an anti-colonialism of healing trauma organized by ideas of colonization as a traumatic past event, wellness as the restoration of health via trauma treatment, and Indigeneity as membership in a trauma-affected population. Further development of this work will require clarification regarding the nature of this clinical condition. If pursued as a clinical disorder or syndrome, as suggested by comparisons to intergenerational PTSD, then clear diagnostic criteria, reliable assessments, and incremental validity over competing concepts (e.g., PTSD) will be necessary. These details have seen little attention since Brave Heart's early writings; however, scholars might look to Chrisjohn, Young, and Maraun's (2006, pp. 101–104) description of "residential school syndrome" as a model for progress (for more on residential school see Child et al., 2014). The widely used Historical Loss Associated Symptom Scale (Whitbeck et al., 2004) documents symptoms of emotional distress related to HT and might also inform diagnostic criteria. Ruling out sociological explanations for AI BH disparities (e.g., "cultural continuity" per Chandler and Lalonde, 1998) and building consensus as to whether HT refers to a specific or general event (e.g., boarding school or colonization; Waldram, 2014) will also be important. Improvements to these areas would be valuable, as criteria for diagnostic legitimacy have changed since HT's early development in the 1990s, and Young's (1995) account of PTSD's development and continued recognition despite lacking a clear causal theory suggests HT theorists focus on reliable assessments and incremental validity rather than clarifying a single causal theory.

However, it may be a challenge to advance this anti-colonialism of healing AI trauma without pathologizing Indigeneity, reifying social narratives of victimry, and obscuring attention to recurrent settler-colonial arrangements. First and foremost, recognition that the vast majority of contemporary AIs do not suffer from a debilitating condition is needed. Inquiry into HT as a clinical condition could turn to demonstrating diverse AI responses to historical encounters with colonial violence (e.g., resilience per Denham, 2008), and work to clarify what events do and do not create debilitating distress in subsequent generations. This work could help create a barrier between clinical narratives of individual pathology and social narratives of collective survivance. Situating this clinical interest in healing trauma alongside the other anti-colonial initiatives could help avoid obscuring ongoing processes of settler-colonialism by re-framing HT-inducing events as violent manifestations of a historically-rooted and recurrent set of relational formations that continue attempting to erode AI sovereignty. In clinical work with clients referencing cross-generational effects of HT, clinicians might also consider HT as an "idiom of distress" (Nichter, 2010). Waldram (2014) has suggested as much, describing HT as a clinical idiom that connects individual suffering to larger, historically-rooted socio-cultural struggles of AI peoples. This approach fits well with Brave Heart's (1995) intention for HT to help avoid "victim blaming and pathologizing" (p. 8) AI hardship, and it offers clinically useful insights into the suffering AI clients might be experiencing and possible routes toward health and wellness (see Hinton & Lewis-Fernández, 2010). Moreover, idioms of distress represent an alternative route toward

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professional recognition of HT by the mental health establishment, which may facilitate the development of new, culturally-informed psychotherapies for more effective healing of AIs.

Promoting Resilience

The second research program engaged HT as a life stressor and advanced an anti-colonialism of promoting AI resilience. This effort has been organized by ideas of colonization a life stressor, wellness as the restoration of health via community health programs encouraging cultural factors alongside standard coping skills and harm-reduction strategies, and Indigeneity as membership in a stress-affected population with cultural resources to help cope with stress and achieve resilient outcomes. Further development of this research will require accumulation of empirical support tying colonial oppression to stress and adverse health outcomes. This work is underway and perhaps best exemplified by a growing body of literature on family histories of Canadian residential school attendance (Bombay, Matheson, & Anisman, 2014). This literature ties intra-personal injury to a specific event rather than Indigenous heritage, which is less likely to pathologize Indigeneity. The research design also minimizes self-report biases—a limitation for much quantitative HT research—by comparing people with and without (verifiable) family histories of residential school attendance on BH indicators. Future inquiry might model this literature by exploring specific experiences of colonial violence affecting specific AI populations (e.g., The Wounded Knee Massacre for Miniconjou and Hunkpapa Lakota) to test contributions of interpretive processes and circumstances mediating or moderating any stable effects identified (e.g., McQuaid et al., 2017). In intervention research, engagement with HT as a life stressor has highlighted the role of AI cultural forms (e.g., identity, healing practices) in supporting health. However, in clinical contexts AI cultural forms are often decontextualized and subtly repurposed to serve familiar clinical functions (Brady, 1995; Hartmann, 2016), which suggests these HT interventionists should consider which cultural forms are amenable to health intervention settings and formats (e.g., structured sessions, reliable and consistent content delivery) and can be incorporated into health programming without enabling their appropriation or misrepresentation.

Advancing this anti-colonial initiative of promoting resilience has much promise, but it is not without challenges. As a framework for health intervention, this engagement with HT has facilitated community cohesion, improved community health outcomes, and provided access to previously suppressed AI cultural forms. Disruption of the cultural forms upon which the health and wellness of AI peoples depended was central to the colonial project (Chandler & Lalonde, 1998), and it is laudable these HT scholars have orchestrated the inclusion of cultural forms (e.g., traditional spirituality) into community health programs. Challenges, however, can be found in making space for survivance stories and attending to aspects of wellness not captured by health indicators. Regarding the former concern, Vizenor (2008) described survivance stories as vital “renunciations of dominance… unbearable sentiments of tragedy, and the legacy of victimry” (p. 1), instilling instead an “incontestable sense of [Native] presence” (p. 11) in the contemporary moment. As such, HT scholars might consider the relevance of postcolonial literary critiques for social narratives they (re)produce through research explaining health disparities as a function of risk and vulnerability related to stress (especially stressors located in history that cannot change).

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Kirmayer et al. (2014) introduced Vizenor's work to the HT literature and highlighted survivance stories as an alternative to the tragedy genre epitomized by comparisons to the Jewish Holocaust. In response, researchers engaging HT as a life stressor might broaden the narrative genres of their writing or rhetorically distance themselves from tragedy. As settler-colonial theorists have argued, one mechanism by which settler states erode the sovereignty and vital presence of Indigenous peoples is through constraining social narrative to promote a sense of victimry and inevitable erasure (Wolfe, 2006). Similar concerns about epistemic violence—the subjugation of non-dominant ways of being (see Teo, 2010)—have been raised in contexts of colonialism where colonial encounters facilitate the subjugation of Indigenous ways of knowing and (well-)being by reinforcing racialized power structures. This is a process social scientists actively participate in (Adams et al., 2015; Teo, 2010), and one decolonial theorists have critiqued with attention to the "coloniality" of knowledge and being in calls to decolonize psychology (e.g., Adams et al. 2015; Bhatia, 2018; Maldonado-Torres, 2007). In contexts of settler-colonialism, these violent processes aim to erode Indigenous sovereignty, which is an important component of AI wellness not easily captured by standard health indicators. This suggests a need for greater attention to the socio-political interests and cultural vibrancy of tribal nations in psychology and health.

Practicing Survivance

A third research program engaged HT as a critical discourse and advanced an anti-colonialism of practicing survivance organized by ideas of colonization as a recurrent set of settler-colonial relational formations that work to erase AI peoples, wellness as a locally defined concept with political dimensions extending beyond familiar health indices, and Indigeneity as a political claim to citizenship in a sovereign Indigenous nation. Where the other two HT research programs saw promise in engaging mainstream psychology and health fields to advance clinical and health interests of AIs—albeit after making modifications (e.g., incorporating cultural factors into therapy or health programming)—these HT scholars critiqued the mainstream discipline, using contextualist inquiry to highlight its shortcomings and instigate change. To further constructive critical reflection in psychology and health fields and improve their utility for advancing the interests of AI peoples, these scholars will need to build conceptual bridges to relevant disciplines that can help realize new understandings of HT's organizing ideas. Several scholars have begun to bridge psychology to history and Indigenous studies (to introduce new ways of thinking about colonization outside the event-response trauma template; e.g., Hartmann & Gone, 2014; Maxwell, 2014), anthropology (to better understand hardship and wellness as locally defined and culturally constructed; e.g., Waldram, 2014), and now postcolonial literature (to better understand relations between clinical, population health, and social narrative). Ensuring critiques maintain broad legibility in psychology and health fields will be important for advancing this work, as is empirical support and illustrations from community-based research.

Advancing this anti-colonial initiative in concert with, rather than in opposition to, other HT research programs has promise and challenges. Since introduction of the HT concept to the literature opened a door to considering histories of oppression in psychological inquiry into AI hardship, scholars engaging HT as a critical discourse have proven adept at uncovering

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colonial arrangements in popular framings of AI hardship (e.g., Gone, 2014; Prussing, 2014; Waldram, 2014). More challenging, then, is critiquing HT research where similar problem dynamics emerge and offering clear implications for different contexts of colonialism. The challenge of critique requires that critical engagement be constructive to facilitate mutual understandings of anti-colonial initiatives and how they might be brought into alignment to cajole psychology and health fields into better serving AI interests. This endeavor requires well-articulated alternatives to the status quo, for which Waldram's (2014) proposal for engaging HT as an idiom of distress rather than a clinical syndrome or disorder is exemplary. One barrier to progress in this direction may be the lack of collaborative initiatives pairing scholars engaging HT as a critical discourse with those engaging HT as a clinical condition or life stressor. This could be resolved in joint efforts of public scholarship or community-based mixed-methods research that captures different engagements with HT and their psychological or health properties. Through such collaborations, critical dialogue regarding the nature and function of HT could be grounded in relevant clinical, health, and community contexts to inform a more precise and impactful HT literature. Moving in this direction may also help address the second challenge of clarifying implications for different contexts of colonialism, not just AI peoples contending with U.S. settler-colonialism, but also Indigenous peoples contending with different manifestations of structural and epistemic violence that echo common patterns of colonial and settler-colonial violence and anti-colonial resistance.

Implications for Racial Trauma Theory

In reviewing the HT literature three engagements with the HT concept were identified, each informing a research program that pursues anti-colonial ambitions informed by ideas of colonization, wellness, and Indigeneity. Although each research program was distinct in its organizing ideas and research design (see Table 1), they also represent three positions along a continuum from which HT scholars have expressed common anti-colonial political commitments with greater intra-personal or socio-structural emphasis. In the resultant conceptual haze owing to engaging HT from differently situated perspectives, further conceptual development of HT and advancement of anti-colonial ambitions have been slowed. However, with critical reflection and dialogue of the promise and challenge for each HT research program, different enactments of these scholars' anti-colonial commitments can be aligned in a more robust, three-tiered effort to make psychology and health fields more useful in addressing pressing problems faced by AIs.

As with HT, RT references a growing body of literature that explores connections between experiences with oppression and hardship and population-level BH disparities using an expanded trauma concept modeled on PTSD. Where HT scholars have focused on colonial violence and oppression, RT theorists have focused on racial violence and oppression to illuminate their largely unacknowledged psychological and health impacts on ethnic/racial minorities (see Carter, 2007; Comas-Diaz, 2016; Bryant-Davis & Ocampo, 2005). In reviewing the RT literature, similar questions might be raised regarding the nature of RT's trauma. To avoid a conceptual haze like that surrounding HT, RT theorists might grapple with possible meanings of trauma for RT and consider the strengths and challenges of pursuing it as a clinical condition (like PTSD), a life stressor (like discrimination), and a

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critical discourse to critique shortcomings of dominant framings of hardship, health, and wellness for ethnic/racial minorities.

First, RT might be engaged as a clinical condition to encourage development of race-informed or otherwise effective psychotherapeutic interventions for ethnic/racial minorities. In summarizing the RT literature Carter (2007) noted that "models of race-related trauma rely on PTSD to indicate race-based traumatic stress injury" (p. 87). Indeed, many theorists have treated RT as a clinical condition involving psychological injury and requiring psychotherapy (Bryant-Davis & Ocampo, 2005; Carter, 2007; Comas-Diaz, 2016), often presenting as evidence clinical case examples of PTSD-like responses to experiences associated with RT (e.g., Butts, 2002; Johnson, 1993). However, while RT is frequently described as originating in a single racist event (Bryant-Davis & Ocampo, 2005; Butts, 2002), scholars have also characterized it as a lifetime accumulation of racist events causing dysfunction upon reaching the "last straw" (Carter, 2007, p. 90), with some positing an accumulation over multiple lifetimes (i.e., intergenerational trauma; Comas-Diaz, 2016; Ford, 2008; Pieterse & Powell, 2016). Moreover, the bulk of RT literature is published in counseling psychology journals where implications of research focus on clinical assessment and treatment (e.g., Bryant-Davis & Ocampo, 2005; Carter, 2007). Thus, it is clear many scholars have engaged RT as a clinical condition requiring psychotherapeutic treatment, which raised concerns in the HT literature about pathologizing Indigeneity, reifying social narratives of victimry, and eclipsing attention to oppressive systems and structures. As a clinical solution to racial violence and oppression, RT theorists can clarify what racist events do and do not cause psychological injury to not pathologize race, distinguish clinical narratives of pathology from social narratives of adversity, and draw upon critical theory to complement RT's trauma discourse with non-clinical discourses of oppression that offer socio-structural analyses of how inequity is maintained and violence reproduced in the lives of ethic/racial minorities (e.g., critical race theory; Crenshaw, Gotanda, Peller, & Thomas, 1995). This concern has been addressed, at least in part, by RT treatment models that encourage client socio-political action as integral to healing and wellness (e.g., Bryant-Davis & Ocampo, 2006; Comas-Diaz, 2016).

Alternatively, RT might be engaged as a life stressor to encourage development of health promotion and prevention programs that mitigate the effects of racial stress. Many scholars have described RT in this way, blending discourses of stress and trauma within a continuum of stress severity ranging from low to high or non-traumatic (able to cope) to traumatic (unable to cope) (Bryant-Davis & Ocampo, 2005; Carter, 2007; Scurfield & Mackey, 2001). In this stress-coping model, ethnic/racial minorities exist in an environment of stressors, large and small, that relate to race interpersonally (e.g., microaggressions) and systemically (e.g., residential segregation) and contribute to trauma directly (e.g., PTSD symptoms, Pieterse, Carter, Evans, & Walter, 2010) and indirectly (e.g., racism as a mediating vulnerability to developing PTSD; Loo, Fairbank, & Chemtob, 2005; Pole, Best, Metzler, & Marman, 2005). Yet, unlike the HT literature, RT scholars have advanced clinical, not community, interventions. Comas-Diaz (2016), for example, detailed a psychotherapeutic intervention for "racial trauma recovery" that included "racial stress inoculation" (health prevention) and "psychological decolonization" (health promotion) in the context of psychotherapy led by a clinician in a clinic. Thus, despite engaging RT as a stressor and

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established literatures on protective factors specific to ethnic/racial minorities (see Theron, Liebenberg, & Ungar, 2015)—with attention to ethnic/racial socialization (Hughes et al., 2006), identity development (Sellers, Copeland-Linder, Martin, & Lewis, 2006; Yip, Gee, & Takeuchi, 2008), and religious/spiritual practices (Koenig, 2009; Whitley, 2012)—RT scholars have not yet turned to advancing participatory community health programs. For HT, this shift from clinical to community intervention supported community cohesiveness and collective resilience; however, it also presented challenges in distinguishing community health narratives of risk and vulnerability from social narratives of adversity, survival, and resistance. RT scholars interested in developing community health interventions would also need to navigate this challenge.

Finally, RT might also be engaged as a critical discourse to challenge predominant framings of ethnic/racial minority hardship in psychology and health and bring attention to racial justice alongside clinical healing and health promotion. It seems RT has not been engaged in this manner, perhaps due to its relatively recent development, but this form of engagement could help advance understandings of RT's organizing ideas (racism, wellness, and race) in psychology and health fields. As such, RT theorists would benefit from interdisciplinary inquiry, drawing upon postcolonial studies to consider a shift in the current focus on racist incidents to a broader interest in racialized adversity, power structures, and colonialism that might move the RT literature in exciting new directions. For example, RT research might converse with anti-colonial theorists like Fanon (1963), who explored psychological effects of racialized colonial knowledge structures on the African Diaspora and concluded the first step toward healing must be a removal of colonial systems and structures. Comas-Diaz (2016) gestured in this direction to decolonial theory by including "psychological decolonization" in her model for RT recovery. RT scholars might also incorporate feminist and critical race theories to formulate experiences as simultaneously racialized, gendered, classed, and tinted by any number of other salient social markers in an intersectional framework (see Cole, 2009, for more on intersectionality). Critiquing constructions of race and racism could help to better understand experiences of race-based violence while pushing psychology and health fields to be more useful in combating structures that maintain conditions of racial oppression. Thus, RT theorists would have much to contribute by engaging RT as a critical discourse, which in turn may invite new language for conceptualizing violence apart from trauma's implied injury. Reparations discourse, for example, situates the problem of disproportionate hardship among some ethnic/racial minorities in a moral framework of injustice to galvanize a response absent notions of intra-personal injury. Coates (2014), for example, invoked a metaphor of debt: "It is as though we [as a nation] have run up a credit-card bill and, having pledged to charge no more, remain befuddled that the balance does not disappear. The effects of that balance, interest accruing daily, are all around us" (pp. 61–61). Here, Coates engaged a discourse of reparations rather than trauma to implicate historically-rooted and ongoing racial oppression in contemporary African American hardship while making clear the need for political and economic solutions, not clinical ones. Engaging RT as a critical discourse, then, might help organize clinical and health initiatives alongside socio-structural frameworks, like reparations, to advance the interest of ethnic/racial minorities in tandem.

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Conclusion

In sum, HT and RT literatures have each brought much needed attention to issues of violence and oppression in the lives of populations historically marginalized in U.S. society and American psychology. These concepts aim to advance the interests of these populations through engaging psychology and health fields with an expanded, yet still recognizable, trauma concept tying hardship to contexts of oppression so as to understand rather than ignore those contributors to suffering and BH disparities. However, the trauma framework offers promise and challenge, which for HT scholars, led to three different modes of engaging the HT concept, each situated in a research program pursuing distinct anti-colonial ambitions organized around different ideas of colonization, wellness, and Indigeneity. RT may be on a similar trajectory toward trauma concept confusion, but through critical reflection on different ambitions and dialogue of RT's organizing ideas (colonization/racism, hardship/wellness, Indigeneity/race), conflicts can be mitigated and a more productive intersectional anti-colonialism/-racism realized in psychology.

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Table 1

Comparison of Three Approaches to American Indian Historical Trauma

Approaches to AI HT	Organizing Ideas			Anti-Colonial Focus		Anti-Colonial Ambitions	
	Colonization	**Wellness**	**Indigeneity**	**Problem**	**Solution**	**Goals**	**Challenges**
Clinical condition	Historical events cause psychological injury for living AIs	Trauma symptoms ameliorated via psychotherapy	Membership in a traumatized population	Intra-psychic	Psychotherapy	More effective clinical healing for AIs	Clarify clinical construct and explore diverse AI responses to colonial violence
Life stressor	Historical events create psychosocial risk for living AIs & repress protective cultural forms	Health improved via community programs incorporating protective cultural forms	Membership in a stress-affected population with cultural resources	Intra-personal	AI health and community resiliency	More effective health programs promoting repressed cultural forms	Distinguish community risk from AI social narrative and attend to socio-political dimensions of wellness
Critical discourse	Persistent societal arrangements erase AIs and naturalize dominance by settler state	Local ideas of wellness advanced via socio-political support for AI sovereignty	Membership in a tribal nation (not related to injury or risk)	Socio-structural	Critique of settler-colonial arrangements in psychology and health	AI emancipation and self-determination	Offer more constructive critiques in legible terms for cross-disciplinary dialogue

Note. Comparison of three approaches to American Indian (AI) historical trauma (HT) (clinical condition, life stressor, and critical discourse), in terms of organizing ideas, anti-colonial focus, and anti-colonial ambitions. Although presented above as discrete categories of engagement with the AI HT concept, each category reflects as a different position along a continuum from which researchers express common anti-colonial commitments with greater intra-personal or socio-structural emphasis.